

**'GETTING TO KNOW THEM': AN EXPLORATORY STUDY OF  
NURSES' RELATIONSHIPS AND WORK WITH TERMINALLY ILL PATIENTS  
IN ACUTE MEDICAL AND SURGICAL WARDS**

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*For Chris, with love and gratitude.*

*&*

*To the memory of Dr David Robins.*



## ABSTRACT

In this study the ways in which a group of experienced staff nurses defined, understood and accounted for their social relationships with terminally ill patients are explored. Two major bodies of social theory – an actor-oriented micro-sociological perspective grounded in the work of Alfred Schutz and Peter L. Berger; and a macro-perspective derived from the work of Michel Foucault – are drawn on to argue:

(1) That social relationships between nurses and patients are rendered problematic by the ways in which nurses defined them as encompassing an interest in the patient as a 'whole' individual. Attention is drawn to the ways in which this individuation is achieved through the production, collation and distribution of knowledge about the patient as a 'public' social actor and as a 'private' subject.

(2) That the problematic status of this social relationship is resolved through its definition as the site of particular forms of work. Here, the patient is designated as more than a sick *body*; and beyond material practices directed at palliating the effects of organic disorder, the patient is the focus of attention directed at penetrating and inspecting the sphere of the private subject.

(3) That work directed at the patient's subjectivity offers not only a potent mode of surveillance to reveal psychosocial 'needs' and 'problems.' This also permits work to adjust the patient's subjective view of social reality and so to integrate him or her into an ideal trajectory that leads to an unproblematic death.

**Declaration**

In accordance with Regulation 3.4.7. of the University of Edinburgh, I declare that this thesis has been composed by myself, and that I performed the research described herein.

**Carl Rossmore May**

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## CHAPTER 1

## EXPLORING THE RELATIONSHIP BETWEEN NURSE AND PATIENT

## 1.1. Introduction: the scope of this study

In this thesis, I present the results of an exploratory study which focuses on the formulation and organisation of relationships between staff nurses and terminally ill patients in the acute medical and surgical wards of a Scottish general hospital.

The central focus of this study was the way in which these nurses defined and understood their social relationships with patients, and this was informed by a more general sociological question: how do actors constitute relationships with others in circumstances that they define as being in some way problematic? Following on from this, I was interested in the practical ways in which problematic elements of these relationships could be resolved.

Although terminal illness, dying and death are not unusual situations in hospitals, they do have particular qualities. In focusing on nurses' encounters with the terminally ill, I was interested in respondents' ideas about the relationship between nursing *work* and the particular qualities of patients' trajectories that were defined as problematic. My starting point was the tension between two specific types of encounter. First, those in which work could be defined in *formal* terms, as being conducted in the public arena of the ward, and in which nurses' tasks and roles are clearly defined in relation to the administration of the patient's institutional career and the performance of clinical procedures. Beyond the orbit of formally prescribed patterns of nursing work, I was interested in *informal* work conducted in private. In these encounters nurses' tasks and roles are less clearly defined and revolve around befriending, comforting and counselling patients in circumstances that fit less easily into the established routines and other social arrangements of the ward.

In framing my research problem in this way I was influenced by a body of research which stressed the organisation of the material practice of nursing work as the key factor in the formulation of relationships between nurses and



patients. This literature<sup>1</sup> emphasised nurses' aspirations for more 'personal' relations with their patients, and explained the disparity between their aspirations and achievements in terms of the ways in which patterns of work organisation and workload inhibited friendly and therapeutically beneficial relations between them. However, as the study progressed I came to see that the informal-formal and public-private distinctions on which the study was based were somewhat misplaced. Nurses' accounts of their relationships with terminally ill patients were dominated by ideas about the conduct of nursing *work*: and relationships were accounted for in relation to specific modes of behaviour through which different kinds of work could be accomplished. This involved work not simply directed at the body, but which also addresses the patient as a *subject*, and in which the social relationship between nurse and patient is itself defined as work.

Within the general research problem that I have described above, respondents' definitions and understandings of relationships were seen not simply as mediating the preoccupations or preferences of individual nurses, but also as the outcome of their engagement with collective forms of definition, legitimation, and regulation. These arise at the juncture between organisational context - through the formal division and direction of labour in the hospital or ward - and occupational culture, in which a particular configuration of social relations, norms, values, and practices give rise to the organisation and definition of appropriate working behaviour to which respondents refer. In this way, the question of how nurses engage with individual patients through the course of their trajectory from admission to death needs to be set in the context of a complex set of social arrangements and seen as a collective accomplishment.

The objective of the study was not to test a rigid, prescheduled hypothesis. Instead, it was intended to explore the social formulation of nurse-patient relationships through the mediating question of how nurses define and understand their relations with a particular group of patients. However, the research question which I have described, and the different levels of interest which I have outlined above, clearly involve a set of assumptions that

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<sup>1</sup> I selectively review existing research on the nurse-patient 'relationship' in chapter 2, and build on that discussion in chapter 9.

constitute this set of social relations as in some way problematic. That they *are* problematic forms the basic assumption on which the study is founded, and this operates as an informal hypothesis underpinning the entire study. But beyond this, the extent and form of their problematic nature remains unresolved within the research design: the object of the study was not to test a set of causal variables within relationships, but rather it was intended to explore the conditions in which these relationships come into being and the ways in which they are accomplished by one set of participants.

This thesis falls into two distinct parts. The first, comprising chapters 1 to 4, sets out the basis of the study in relation to existing research and to theoretical and practical aspects of the research method employed in its conduct. What I was anxious to do in these chapters was to give as full an account as is reasonably possible of the way in which the study was conducted. The second part of the thesis uses the patient's trajectory or career to carry forward my argument: dividing it into three distinct stages: in chapter 5 I examine that period in which the patient is incorporated into the hospital ward; in chapter 6 I focus on the period in which the patient's prognosis is decided, and discuss some of the issues that surround its disclosure to patients and their relatives; and in chapter 7, I examine the ways in which the nurse-patient relationship is reconstructed in the period after disclosure. I do not deal with the events that surround patients' deaths for two reasons. First, patients whose trajectory is anticipated to be lengthy tend to be moved on from the general medical and surgical wards at the hospital in which this study was conducted, either to be returned home into the care of their general practitioner and district nurse, or to become a resident in one of the several hospices in the area; and second because respondents' accounts themselves led me in the direction of work *with* the patient, and focused on how this could be best conducted. I have tried to deal with the questions that this emphasis raised in chapter 8. In chapter 9, I draw together some of the theoretical issues through which respondents' descriptions of their work and relationships with terminally ill patients can be understood.

## **1.2. The place of nurses in the sociology of health and illness**

This study is intended to contribute to the sociology of health and illness. However, sociologists whose research interests lie in the examination of

institutional aspects of health care and the health professions have largely, and perhaps inevitably, focused on the knowledge base, members and activities of the medical profession, and on their relations with other groups in society. While sociologists' relationships with the medical profession have not been unproblematic, as Uta Gerhardt (1989) and Karl Figlio (1987) have reminded us, it has been the medical profession that has remained at the centre of their collective gaze. Nurses, on the other hand, have historically not achieved great prominence in 'medical' sociology and it is remarkable how little attention has been paid to them in the research literature, or in the undergraduate and graduate texts and readers through which 'new entrants' engage with 'medical' sociology as a field of specialisation. My own view is that nurses are rather more prominent and important in the experience of patients (and doctors) than the extent to which they are included in this body of literature would have us believe.

Nurses perform the bulk of everyday care in hospitals and far outnumber all other health professionals, and this reason alone seems to me to be grounds to insist on their being given a more central place in the frame of reference defined by sociologists of health and illness. This is not to suggest that significant empirical and theoretical work has not been published, and there certainly have been a number of major interventions in this field, in which nurses are given a much greater degree of visibility. It is worth pointing out, however, that as graduate programs and nursing faculty have proliferated first in the US and then in this country, much of this work has actually been undertaken by nurses themselves. By way of emphasis, the major academic journal in this field in the UK, *The Sociology of Health and Illness* contains 11 papers which focus on nurses as central actors out of a total of 198 in the period 1979-89.

I am not arguing here that 'medical' sociology should focus primarily on nurses, but I do argue that they deserve more attention than they get. It is worth comparing British sociology's fixation with the doctor as an authoritative *professional* with the way in which sociologists of work and industry have focused much more directly on subordinated workers in other sectors of the labour market. The massive expansion of critical attention in this field after the publication of Braverman's *Labour and Monopoly Capital* (1974), can be compared with the way in which critical attention in 'medical' sociology has generally addressed powerful doctors rather than less powerful nurses. In fact,

radical critique has arrived not from those sociologists whose, (largely Marxist, as Philip Abrams, 1981, has noted), interests lay in emancipation of workers from oppressive systems of work organisation, but rather less surprisingly from feminist social critics and sociologists – although sadly much of their attention has been directed at the position of midwives. The second major source of 'sociological' examination has been, as I have already noted, nurses themselves and this is demonstrated by the steady flow of papers with a broadly sociological perspective in the *Journal of Advanced Nursing* since its inception in 1976.

## CHAPTER 2

### THE SCOPE OF EXISTING RESEARCH

#### 2.1. Introduction

Since the beginning of the 1960s nurse-patient interaction and nurse-patient relationships have become increasingly important topics in nursing theory, education and research. During this period, empirical studies of interpersonal relations between nurses and patients have proliferated, generating a mass of data about the forms which these take.

This chapter has two objectives. First, it provides a selective overview of existing research material on nurse-patient interaction and relationships: and this falls into two main bodies of literature.

- Research about the communicative action of the nurse at an individual level, focusing on the dynamics of dyadic interaction at the bedside.
- Research which contextualises interaction through relating it to the way in which the social organisation of nursing creates conditions in which different forms of interaction and relationships are promoted or inhibited.

Although the literature discussed in this chapter ranges across a number of nursing specialisms, a remarkable feature of research about interaction between nurse and patient is the way in which this seems to be consistent across a wide range of clinical contexts, as Macleod Clark (1982) and Heyman and Shaw (1984) have pointed out.

The second objective of the chapter is to explore the way in which nurse-patient interaction and nurse-patient relationships have come to be seen as problematic and have been constituted as areas of research interest. Underpinning this process are assumptions and ideas derived from a range of theoretical and ideological sources which have acted to frame research questions, and to determine the perspective from which research has been directed.

## 2.2. The moral failure of the nurse? Technocratic perspectives on the limits of verbal interaction

Existing research shows that nurses view relationships with patients as an important part of their nursing care, (Field and Pierce-Jones, 1967; Hockey, 1976; Moulton *et al*, 1978; Field, 1984; 1989). Alongside the development of this body of research, a literature has emerged which stresses the importance of nurses constructing interpersonal relationships with patients that meet therapeutic objectives, in that the nurse is able to identify patients' psychosocial and emotional needs within them.<sup>1</sup> However, a considerable body of research has accumulated which suggests that in practice nurse-patient interaction is profoundly limited. Much of this research has been concerned with the frequency, duration, and attributes of verbal interaction at the bedside – focusing on its immediate qualities.

In a number of these studies, nurse-patient interaction is implicitly defined as a technical problem of practice,<sup>2</sup> and, in fact, these technocratic accounts of nurse-patient interaction have come to be directed at how therapeutic interaction is *not* practiced. From the perspective of this chapter, such accounts offer a range of valuable, detailed data about the mechanics of dyadic interaction between nurses and patients. However, they need to be connected with other research – especially about the way in which nurses perceive interaction in relation to other aspects of both practice and the conditions in which it is undertaken.

### 2.2.1. Temporal limits on nurse-patient interaction

A number of studies have pointed to the limited duration of nurses' verbal interactions with patients. In their study of geriatric care Adams and MacIlwraith (1962) reported that only 1% of nurses time was spent in conversation with the patient. Quint (1967), in her study of student nurses' interactions with dying patients also noted the limited length of conversations,

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<sup>1</sup> I discuss this more fully in the latter half of this chapter.

<sup>2</sup> Quint, 1966; 1967, Sudnow, 1967; and Peterson, 1988 being the notable exceptions.



as did Lysaught (1974), who also suggested that these were episodic in their nature. Wells (1975), reported that in a geriatric ward 4% of the nurses' time was spent in 'personal contact' with patients. Of this, 50% lasted for periods of 25 seconds or less. Stockwell (1972), also observed that verbal interaction was infrequent and short.

Keck and Walther (1977), researched the commitment of a group of nurses to providing explicit psychosocial and emotional support to dying and non-dying patients. They showed that the mean duration of verbal interaction between nurses and patients was 2 minutes 20 seconds. Interestingly, they were unable to demonstrate any differential in the length of interactions between dying and non-dying patients with known prognoses. However, they did note that a marginally greater length of time was spent by nurses with patients whose trajectory and prognosis was uncertain.

Moult *et al* (1978), in a study of the effects of different forms of ward organisation, found that verbal interaction unconnected with another nursing task averaged 0.75 minutes. Where it was connected with another nursing activity it fell into a range of 0.5 – 9.5 minutes. Similarly, Bond (1978), reported that in a hospital radiotherapy department less than 5% of verbal interaction extended beyond three minutes unless directly connected with a sequence of nursing tasks being performed on the patient. Faulkner (1980), also showed an average of 2–3 minutes per interaction in her investigation of the communicative efforts of student nurses. Faulkner also observed that male patients were involved in shorter encounters than female patients.

Macleod Clark (1982), has produced one of the most comprehensive and methodologically exacting accounts of nurse–patient interaction at the bedside, using a combination of radio microphone and audiotape, in conjunction with video recordings. These were then analysed using complex techniques of content analysis to describe 56 hours of nursing activity on several wards, in which 310 interactions took place. The overall average length of these was 1.7 minutes, (for student nurses 2 minutes, and for staff nurses 1.3 minutes). However, these average figures are distorted by a small number of very long

conversations and she argues that they should be treated with caution.<sup>3</sup> In fact, the median length of verbal interactions in Macleod Clark's study was 1.1 minutes.

Typically, the duration of verbal interaction is short and very little of nurses' total time on the ward seems to be taken up with it, 1% in Adams and MacIlwraith (1962), 2.4% in Moulton *et al* (1978) and 15.8% in Macleod Clark (1982). However, these results need to be viewed cautiously since they reflect a range of sample sizes and techniques of calculation.

### 2.2.2. Limits on the content of nurse-patient interaction

In the previous section I discussed research evidence which showed that the typical verbal interaction between nurse and patient is of short duration. A much greater body of evidence exists that shows how the *content* of verbal interaction between nurse and patient is also profoundly limited. Although Hockey (1976), Field and Pierce-Jones (1967) and Field (1984) have shown that nurses wish to invest more time in meeting the psychosocial needs of the patient there is little evidence to suggest that this takes place. In fact much of the research discussed in this section concludes that the typical verbal interaction is superficial, task oriented and that nurses avoid the discussion of patients' emotional and other psychosocial needs. However, there is also some evidence to suggest that patients are reluctant to discuss these with nurses, as Heyman and Shaw (1984), Macleod Clark (1982), Stockwell (1972) and Cartwright (1964), have noted. It is apparent that patients tend to perceive nurses as too busy to spend time talking, or that to do so might distract nurses from the business of nursing the more seriously ill.

In the care of the terminally ill, the problems of responding adequately to the psychosocial and emotional needs of the patient are clearly more complex and demanding than those encountered with patients who have a favourable prognosis. However, as with the temporal limitation of nurse-patient interaction, it seems that the characteristics of the content of these encounters

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<sup>3</sup>A similar caution should, of course, be applied to other studies which present results based on averages, notably Keck and Walther (1977)



are broadly similar across a range of clinical specialisms.

Quint (1966), in a study of interaction between nurses and mastectomy patients found that:

nurses were able to avoid conversational difficulties with patients by using tactics which directed the discussion into safe channels (...) the nurse could focus attention on the procedure being done, or could teach the patient about such matters as arm exercises, or could make small talk (1966:52).

Quint also found (1967), that student nurses distracted patients through making small talk and social conversation that focused the patient on the world outside of the hospital. Sometimes this was especially difficult with terminally ill patients. Coser (1962) and Sudnow (1967) have suggested that this takes place with terminally ill patients across a range of illness and awareness contexts. Stockwell (1972), found that interactions on a geriatric ward were almost entirely task oriented and superficial, and that some tasks took place with no verbal exchanges at all. Other studies of geriatric care have confirmed this: Wells (1975), found that 75% of all verbal interactions in his study took place while nurses were performing physical care. Where 'personal' conversation took place it was found to be superficial and routinised. Dodd (1974), has produced similar findings in work on general wards: reporting that nurse-patient interaction was limited and that even when they were not busy nurses did not spend time with patients. A similar pattern emerges in Moulton *et al* (1978). Maguire (1978) found that patients in distress were not encouraged to discuss the sources of their concern, and again, in that study nurses appeared to attempt to divert attention away from psychosocial problems or to ignore them.

Maguire *et al* (1980) report that only 1 in 20 interactions between nurses and patients were concerned with patients' psychosocial and emotional responses in a general surgical ward on which surgery for breast cancer was being performed. In this study it was shown that although nurses seemed to spend more time with patients encounters between them were still task oriented. The patients in this study seemed to be passive, feeling that nurses should not be burdened with their problems, and making strenuous efforts to appear to be coping, even when in great distress.

Maguire's results are similar to those of Bond (1978), who found that in a radiotherapy department nurse-patient interaction was limited to task oriented procedures and social conversation. Nurses worked to avoid the patient dwelling on his or her condition, and argued that it was better not to discuss this in detail to avoid demoralising the patient. The superficiality, routinisation and task orientation of nurse-patient interaction has also been noted by Faulkner (1980), MacIlwaine (1983) and Knight and Field (1982).

Macleod Clark (1982; 1983) has shown that nurses use a specific set of conversational devices to block communications that deal with anxiety and emotional issues. Although these will be discussed more fully in another section it is important to note that in her study nurses 'were shown to use few strategies which reinforced patients in conversation [and] means of encouraging patients to converse were also rarely identified' (1983:52).

Peterson (1988) observed three groups of nurses on general medical wards. Her respondents demonstrated a high degree of knowledge about the importance of supporting the patient at a psychosocial level, and of responding adequately to their emotional problems and anxieties. However, Peterson found that in practice this theoretical knowledge was not acted upon. Where verbal interaction took place it was limited to issues of direct, physical nursing care, and to explicit verbal requests for this. As with the temporal limits on nurse-patient interaction the pattern of content limitation is consistent across a range of clinical contexts.

### **2.2.3. Initiation and termination**

The relative immobility of patients may make it difficult for them to initiate encounters with nurses, and this may be exacerbated by wards laid out in bays or in small rooms which make it difficult for the patient to attract the nurses' attention. MacIlwaine (1983), has also observed that nurse-patient interaction takes place for many purposes other than the construction of therapeutic relationships and the offering of particular kinds of emotional support. It is important to note that in the course of the ward day, the patient will encounter a number of different nurses involved in a variety of clinical, administrative, and domestic tasks: in consequence many encounters between them will have a clear purpose – the eliciting of information, giving of instructions, or making of requests – related to a very wide range of matters. The formal and specific

nature of much of this interaction may explain why such a large proportion of interactions appear to be task oriented and short, although it clearly does not explain why others are superficial.

There is not an extensive literature on the initiation and termination of nurse-patient interaction, but from that which does exist its characteristics seem relatively clear. Moulton *et al* (1978) report that their observation of the initiation and termination of interactions demonstrated that the majority of them were initiated by nurses. In 239 observed conversations, 183 were initiated by nurses: of these 150 were terminated by nurses and 18 by patients, 56 were initiated by patients: and of these 41 were terminated by nurses, and 3 by patients. The remainder were either interrupted, or uncoded. Similarly, Macleod Clark (1982) reported that of the 310 interactions in her study, 83% were initiated by nurses.

#### **2.2.4. Control of nurse-patient interaction**

The question of control over nurse-patient interaction is closely connected to the different ways in which it is limited. It is important not to underestimate the power of nurses to set the agenda of encounters, and the range of conversational tactics available to them. In the preceding discussions about research on the limits of verbal interactions, I have pointed to the way in which they seem to be organised around nursing tasks, and the apparent failure of nurses to create 'spaces' in which patients' anxieties and emotional 'problems' can be resolved.

Menzies (1970); Quint (1966, 1967); Duff and Hollingshead (1968); and Stockwell (1972), have all suggested that nurses take a dominant role in the control and delimitation of encounters with patients. Quint (1967) has suggested that small talk and inconsequential conversation are part of a deliberate strategy to distract the patient, along with focusing conversation on nursing tasks. We have seen, too, that similar observations have been made by Wells (1974); Ashworth (1976); Bond (1978); and Faulkner (1980).

Bond (1978), reported that when patients attempted to use their encounters with nurses to discuss the psychosocial aspects of their illness nurses engaged in tactics to minimise this. Bond argues that nurses organise their verbal interactions in such a way as to restrict the information that they receive from

the patient. In her study, nurses argued that minimising the discussion of illness allowed the possibility of recovery to be maintained against the real uncertainty of the patient's prognosis, and so acted to minimise distress. The moral dilemmas consequent upon this were resolved through the argument that they were acting in the wider interests of the patient.

Knight and Field (1981) studied an acute surgical ward on which the majority of admissions were for cancer. They suggest that the general principle underlying nurse-patient interaction was that nurses were superior by virtue of their expert knowledge and status. They also suggest that encounters were routinised and organised around technical and domestic aspects of nursing care, and go on to suggest that this was part of the general management of communication between the nurse and the patient. The set of practices involved here seemed to have a clear purpose:

- to ensure consistency in the sort of information given to patients by staff;
- and, to ensure that staff did not come into conflict over what patients should be told.

The mechanics of the restriction of nurse-patient interaction, and the diversion of conversation – the way in which the nurses' power to set its agenda is manifested – have been comprehensively described by Macleod Clark (1982). Her study revealed several different conversational tactics:

- closed questions, leading to simple yes/no answers;
- leading questions, which limit the range of answers;
- a rapid succession of questions, which leave the patient uncertain about what answer to give;
- and, direct statements.

Clearly, these tactics are not always inappropriate. However, Macleod Clark reports that they appear to be used consistently, and are a powerful influencing

factor in the control of encounters with patients.<sup>4</sup> A second set of equally powerful tactics also emerged from the study, in which the nurse acts to respond in a negative way to questions and cues from the patient:<sup>5</sup>

- through vague replies, or very general comments;
- through apparent recognition of the cue or question, followed by the nurse changing the subject;
- through directly changing the subject;
- or through 'failing' to recognise or acknowledge the question or cue.

Although the general tenor of much of the research into verbal interaction between nurses and patients is very negative, this study also demonstrates the very positive ways in which nurses encourage and support patients through reinforcing their attempts to communicate. However, these are relatively infrequent compared with the more discouraging approaches that they make, and which provide the nurse with a range of practices through which to direct and curtail encounters with patients.

So far, I have discussed research material which points to the limits of dyadic interaction between nurse and patient. Macleod Clark (1983), asserts that a review of this literature brings into view three general conclusions:

- Nurses spend little time in verbal communication with patients and that when interaction does occur, it tends to be superficial and task oriented.
- Nurses use a range of tactics to avoid communication.
- Nurses attempt to control *all* interaction in order to limit the 'quality and depth' of verbal communication with patients.

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<sup>4</sup>It is important to note that Macleod Clark leaves open the question of whether such tactics are deliberately employed, and intended to limit nurse-patient interaction and if this is so, what the motive for this is.

<sup>5</sup>Macleod Clark characterises a cue as a statement or indirect question identified as an attempt to elicit a response from the nurse.

For Macleod Clark, these findings raise questions about the *dynamics* of nurse-patient interaction: and these are oriented around the extent and sources of control and limitation, and about the degree to which these are consciously motivated. She argues that, historically, research has failed to approach these questions because it has neglected the dynamics of communication; and because research definitions are not conjoined with appropriate methods, so failing to generate data in a form through which dynamic questions could be resolved.

The outcome of Macleod Clark's study was a set of results derived from conversational analysis. However, her analyses of interactions focus on the immediate encounter between nurse and patient and the form of verbal exchanges that this involves. While this approach provides comprehensive data about the forms and qualities of interactions, it leaves open the question of the contexts in which they are performed. There is a real problem here, in that the social and organisational context of interaction plays a powerful role in determining the form it takes. The possibility that the nurse differentiates between types of interaction, or uses tacit knowledge to assess the needs of the patient is neglected in this type of study, which homogenises interactions – implicitly setting them in a neutral context – rather than placing them in the wider context of the social organisation of the ward.

To explore the social relationships in which dyadic encounters between nurse and patient are located, and to move beyond the specific dynamics of the interaction, we need to engage with a much broader body of literature. In the next section, the review focuses more directly on the encounter between the nurse and the terminally ill patient.

### **2.3. The moral failure of nurses? Patient stereotyping and defensive nursing**

Moult *et al* (1978), suggest that research evidence shows that nurses would like to spend more time in contact with the patient and that it would be therapeutically beneficial to the patient if this increased contact took place. However, in the preceding discussion, I have pointed to a range of research which seems to show that, whatever the aspirations of nurses, in practice nurse-patient interaction takes on profoundly limited forms. A research perspective which focuses on those aspects of interpersonal encounters between nurses and patients which are in some way quantifiable, (and from



this position draws inferences about the nature of their social relationship), may tell us very little about *why* interactions are routinised or superficial. However, an extensive literature has emerged which offers explanations for the limited quality and depth of interactions by pointing to the ways in which patients are perceived in terms of stereotypes, and at the very high levels of stress which nurses experience at work.

### 2.3.1. Stereotyped perceptions of the patient

The first conventional explanation for the delimitation of nurse-patient interactions and for its apparently superficial content is organised around the ways in which nurses perceive patients, and characterise them according to stereotypes which have the effect of denying their individuality. As Davis (1984) has argued:

although nurses claim now to have been concerned with the whole patient, with developing nurse-patient relationships, with individual patient care in the past, and although the trend over the past few years has been towards the individualised, planned, and documented care of the nursing process; there is much evidence to suggest that then as well as now, nurses tend to deal with types of people, types of behaviour, and types of disease, rather than individuals (1984:70).

Similarly, Gray (1977), reporting on her study of the nursing care of dying patients in a hospice, observed that:

many of the nurses spoke of the importance of considering each patient as an individual, but none specifically mentioned problems which may arise because of the patient's individuality, (1977:64).

A number of studies have pointed to the way in which patients are depersonalised through medical discourse, with its concentration on signs and symptoms of physiological and psychiatric disorder and disturbance. Beyond this lies the way in which nurses apparently ascribe, or project, clinical or social characteristics onto patients which categorise them according to 'types'

or stereotypes, through which nurses' perceptions of the patient are translated into a particular mode of response. As Kelly and May (1982) have argued in an important review of the literature, research in this area has led to contradictory and conflicting data that is difficult to deploy systematically. They suggest that many studies concerned with the way in which labels are applied, and of the criteria used to deploy them, are founded on inadequate methodological practice, and on poor epistemological and theoretical bases. Within these studies the sources of problematic categories of patient, and the ascription of the categories themselves are not adequately confronted. A further problem is the way in which these categories become seen as fixed, without any possibility of negotiation, or change over time.

There is reliable evidence, however, that some clinical and social characteristics do play a major role in eliciting problematic perceptions of the patient by nurses. Psychiatric disturbance and violence (Stockwell, 1972; Jeffrey, 1979)<sup>6</sup>; disfigurement (Stockwell, 1972; Simpson *et al*, 1979); foul odour and incontinence (Williams and Williams, 1959; Simpson *et al*, 1979); chronic and long term illness (Duff and Hollingshead, 1968; Peterson, 1967; Melia, 1981) have all been cited as being the source of nurses' negative perceptions of the patient.

Terminal illness has also generated a contradictory and variable literature on this account. Knight and Field (1981) and Simpson *et al* (1979) found that patients were perceived in a problematic way, as did Strauss *et al* (1968). Melia (1981) found that her respondents varied in their response, as did Quint (1967), Keck and Walther (1977), Gow and Williams (1977), and Field, (1984). Strauss *et al* (1968) have shown how perceptions of the patient change according to context and time, and have emphasised the importance of the patient's response to the nursing staff, and to nursing care, in the complex processes of interaction and legitimation which take place between the nurse and patient.

Where the patient's legitimation of nursing care and associated activities are in

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<sup>6</sup>Silverman (1985) points to the way in which Dingwall and Murray (1983) elaborated Jeffrey's categories to assert the possibility of patients being not simply 'good' or 'bad' but being located in an intermediate category in which they are viewed as 'legitimate but routine'.



question, the nurse's perception of the patient typically involves issues of compliance and dependence. Heyman and Shaw (1984) report that in their research:

80% of bad relationships with patients were described in terms (...) categorised as non-compliance, such as complaining, demanding, ingratiating, and disobeying, while only 15% of non-patients were so described. This is consistent with findings in other research that fear of breakdown of control is more salient for nurses in their relationship with patients (1984:70).

Heyman and Shaw observe that there is a discrepancy between the way in which nurses perceive relationships in a general sense, and the criteria which they use to judge individual patients. They point to Copp's (1971) study, which showed that nurses perceived the typical patient as frightened, anxious, or bewildered; while in a projective test, these qualities were recategorised as complaining, demanding, and asserting. Heyman and Shaw emphasise the range of studies which show that patients who are the source of least disruption to nursing work and ward routine are categorised in the most positive way by nurses.

The sources of these variant 'labels' on patients are complex and ambiguous. Clearly, issues of compliance and disruption are important, given that the patient can create difficulties for staff by interfering with the allocation of scarce nursing resources to other patients, or through refusing to accept care or treatment. Such patients are a common feature of literature concerned with psychiatric or psycho-geriatric nursing, but rarely appear in research on terminally ill or dying patients outside of these clinical areas.

Similarly, May and Kelly (1982) have emphasised the importance of patients legitimising the nurse's role by responding to it in a way that reinforces her or his position and presents no challenge to its authority. Heyman and Shaw (1984) suggest that in the vast majority of studies directed at patient stereotypes, those patients who consistently receive the most positive evaluations from nurses are those who present no problems of disruption or legitimisation. However, research which is focused on the definition of patients as in some way problematic, inevitably neglects the large mass who present no legitimative or disruptive problems - characterised by Dingwall and Murray (1983) as routine - although it needs to be noted, (as Macleod Clark, 1982

points out), that there is no evidence that they experience qualitatively different verbal exchanges with nurses. This leaves open, then, the question of why patients seem to be locked into a set of routinised, superficial, and delimited encounters with nurses.

### 2.3.2. Control and occupational stress

The second conventional explanation for the delimited forms which nurse-patient interactions take is, as Macleod Clark (1983) has observed, one which stresses the way in which the control and delimitation of encounters may perform a defensive function against the stress and anxiety experienced by the nurse in daily confrontation with pain and illness, and which emphasises the tensions nurses encounter if they do enter into personal relationships with patients.

Menzies (1970), argued that task allocation, and routinisation of work performed a defensive function militating against patient-staff relationships, preventing staff from coming into too personal a contact with any one patient, and hence militating against personal anxiety. Depersonalisation, through categorisation of patients by their symptoms, is another manifestation of this defensive process - according to Menzies - acting as a denial of the significance of the individual.

Casee's (1975) study of Dutch nurses suggested that while patients were provided with adequate information about the tasks that nurses were performing, nurses avoided intimacy and involvement with them. Casee argues that the 'social structure' of the ward militated against personal contact with patients, and the therapeutic relationships that are consequent upon this: and this is the result of a hospital culture that minimises personal contact. There are four main strands to his conclusions:

- That the breaking down of nursing activities through an 'extreme division of labour' privileges procedures and tasks over interactions; and so renders nurse 'immune' to the psychosocial condition of the patient.
- That the patient is depersonalised through a hospital culture that identifies them according to their pathology: and that nurses are similarly depersonalised through their professional status, working in relative emotional isolation from each

other.

- Nurses attempt to restrict their 'emotional output' within the ward through recourse to 'professional attitudes' - that ensure that the nurse remains detached from the emotional stress caused by personal relationships with the patient.
- That task performance is ritualised through routines that disassociate their practice from the individuals that they are practiced on.

Menzies and Casee both locate the sources of blocks on interaction in a collective and culturally based defence against the stress of working with sick patients: and Llewelyn (1984) has pointed to the range of evidence about the very high levels of stress experienced by nurses. In the case of terminal care, she argues, this is exacerbated by the way in which the expression of emotion by staff is largely suppressed, and construed as a sign of weakness.

Folta (1963) reported that in a Canadian study nurses tended to avoid dying patients as they became more experienced, and (1965) that they registered very high levels of stress and anxiety, because they were less able to avoid 'unpleasant duties' than aides (auxillaries). Schoenburg (1968) has suggested that this avoidance behaviour itself leads to higher levels of anxiety, results reflected by Gow and Williams (1977). Braider and Porath (1981) have pointed to the extremity and variability of stress and anxiety suffered by the nurse in contact with terminal patients. They suggest that nurses display a remarkable ambivalence:

in reaction to the patient's death, alternatively approaching and avoiding contact (...) encounters with patients induced avoidance behaviour because they involved looking death in the face (...) it became more and more difficult to separate professional roles and private feelings (1981:50).

Similarly, Vachon *et al* (1978) describe stress among nurses working with advanced cancer patients as slightly higher than that experienced by newly widowed women, and considerably higher than that experienced by women beginning treatment for breast cancer.

A major source of stress seems to be nurses' uncertainty over how to respond

to the patient; one of Braider and Porath's respondents saying:

Respondent: [H]e knew he was dying. I am sure that he knew, but I could not bring myself to discuss it with him. I was afraid and didn't know what I should say. Then I tried not to think about it (...) I had terrible nightmares and felt angry and lost (1981:50).

Respondents in Keck and Walther's (1977) study were reported to show a similar uncertainty about how to respond, as well as doubts about what the psychosocial needs of patients *were*. Stoller (1980) also reports nurses reacting ambivalently to the terminally ill or dying patient and locates the source of this, partially at least, in the nurse's own death related fears.

Birch (1975;1983), found a relatively large sample of student nurses (n=207) to be highly anxious about specific activities: nursing patients in severe pain; dealing with patients with cancer; care of the terminally ill; and care of the dying, were consistently in the five most stressful and anxiety causing activities in a longitudinal study of this group throughout their training.

Bond (1978) has pointed to the central importance of relationships between staff in the generation of conditions in which meaningful relationships between nurses and patients can come about. Here, nurses' own 'fears and problems of identification may be projected onto other staff as well as patients' (1982:17). In such situations, Bond asserts, nurses demand high levels of support from each other, from senior nurses, and nurse managers; and when this is not forthcoming friction and hostilities occur that mirror and intensify existing hierarchical relationships. In the US, Decker (1985), has suggested that interpersonal conflict between nurses is a major source of job stress: however, only 4% of British nurses surveyed by Shaw and Heyman (1980) identified interpersonal conflict as a source of problems at work. Vachon (1987) has argued that it is the conditions of work, rather than interpersonal relationships that are the primary source of stress for those working with the critically or terminally ill.

The relationship between occupational stress and interpersonal conflict has generated a variable and contradictory literature. Historically, this has been focused on types of nursing work that are supposed to be highly stressful -

often because of their specialised and technologically based nature – for example, ICU and CCU,<sup>7</sup> and has compared these with different kinds of general medical nursing. Vreeland and Ellis (1969), and Hay and Oken (1972) argued that ICU and CCU nurses were subject to much higher levels of stress than general nurses. Gentry *et al* (1972) claimed that nurses in highly specialised areas also experienced much higher levels of personal anxiety and interpersonal hostility; while De-Nour and Czaczkes (1968) reported that frustration and aggression with patients is displaced into tensions within nursing teams.

However, more recent work has undermined, and to a certain extent reversed, the trend towards seeing highly specialised nursing work as more stressful than that experienced by general nurses. Johnson (1979), Maloney (1982) and Keane *et al* (1985) have described lower levels of stress and anxiety in specialty nurses than among their general counterparts, while Nichols *et al* (1981) reported that nurses working in ICU registered significantly higher levels of job satisfaction and morale.

In a comparative study of general medical, geriatric, CCU and renal unit nurses, Hipwell *et al* (1989) show that responding to terminal illness is a significant stressor for nurses irrespective of specialty. However, they report that nurses working in general medicine and geriatrics suffered much higher levels of stress related to pressure of work, lack of interpersonal and management support, and staff conflict – confirming the position adopted earlier by Nichols *et al* (1981).

It is important not to underestimate the stresses and anxieties that nurses experience when they work with terminally ill patients. However, it is significant that anxiety and stress appear to be intimately connected to the patient's awareness of their condition, and to the extent to which the management and organisation of the ward – and its occupational culture – promote or inhibit nurses' responses to this.

Research which emphasises the stereotypical characteristics of patients, and the stresses which nurses may experience in their work needs to be engaged with other research to make the connection between interactions and

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<sup>7</sup>Intensive Care Unit, and Coronary Care Unit nursing, respectively.

relationships constituted through work, and the material and cultural conditions in which work is carried out. Since the mid-1970s a number of research projects have suggested the ways in which the division, organisation, and definition of labour, as well as its regulation and direction, exert powerful forces over the form which interactions and relationships take.

#### **2.4. The moral failure of the workplace? Contextual accounts of interaction and relationships**

The dynamics of nurse-patient interaction and the normative behaviour of the nurse at the bedside are the outcome of a complex of social practices and processes, rather than simple, individual choices made by nurses. The discretion and autonomy of the nurse to constitute interactions with patients is clearly an important factor: however, this needs to be balanced against a range of formal and informal factors which combine to define the boundaries of appropriate and inappropriate interactive behaviour.

In the case of nursing terminal and dying patients, protocols about *disclosure* act to formally circumscribe interaction. In the US and UK, only the patient's physician is legally permitted to offer diagnosis and prognosis. On an informal level, the amount and quality of information available – especially to junior and student nurses – varies.

Secondly, interactions and relationships are circumscribed by the way in which nursing work is organised and defined. A number of studies have pointed to the central importance of the way in which nursing work is defined through material tasks and practices of care. This raises the possibility of 'interaction' and 'relationship' being apprehended as important elements of nursing *behaviour*; but excluded from practical definitions of nursing *work*

Thirdly, it must be emphasised that nursing is a group activity. Nurses do not work in isolation from each other; but as part of a relatively cohesive and solidaristic group. Peterson (1983) found that nurses are strongly influenced by the norms and values of their immediate work group: and emphasises (1988) that patients interact with a number of nurses working in concert.

One way of exploring these different factors is to look at the experience of the student nurse in the course of induction into work, and to counterpose this



with the experience of qualified nurses working with the terminally ill in different settings. The next section uses Melia's (1981;1987) work on student nurses accounts of their training in general hospitals as a case study of the way in which 'fitting in' to an occupational culture is negotiated.

#### 2.4.1. Autonomy and Work Culture

These accounts are organised broadly around themes reflecting the experience of subordination within both an occupational culture and organisational structure. In their first months of training, students perform largely routinised tasks of limited complexity and technical sophistication: at the same time being immersed in an atmosphere of personal, moral responsibility. While tasks may become increasingly complex and demanding as training progresses, this high level of personal responsibility exists in tension with the students' lack of autonomy and discretion over the way in which they work. The way in which nurse training is organised means that the student population is deployed as a flexible and mobile labour force within the hospital, fragmenting the students experience as they move through a variety of settings and specialisms. Furthermore, the modular and fragmented format of training, in combination with the way in which students are deployed as a reserve of labour within the internal labour market of the hospital, means that students are disassociated from permanent staff, and patients. Their rapid transit through a number of wards, and their assignment to routine and domestic tasks means that 'simple forms of labour' form the dominant experience of work for the student.

Subordination and routinisation are located not just in the hierarchical and ideological (Williams, 1974), formations that the student is immersed in, but in the social controls and informal pressures around which the social definition of work is organised, and through which autonomy and discretion are mediated. Critical in this is the experience of being defined as a *worker* by qualified staff. Melia (1987) suggests that the student occupies a position analogous to that of the unskilled auxillary, and that it is at this level that their tasks and performance are defined and evaluated by qualified staff. While students perform domestic and routine tasks: ie. 'work', qualified staff have greater discretion to specify their own tasks.

Throughout their training nurses have been used to the

notion of a nursing hierarchy on the ward. Those at the top are able to pick and choose what work they do, while those at the bottom must 'get the work done'. This system is justified by the fact that students pass up through the system to a position where they too may become more selective in the work that they do. (1987:79)

In this context, interactions between qualified staff and students are evaluative and task centered; while the transitory and interchangeable nature of the student makes it difficult to establish informative relationships with qualified staff, and patients. The efforts of the student are devoted to 'fitting in' to the particular configuration of rules and practices on new wards with qualified staff who have historically established patterns of work and work relationships. The progress of the students in these circumstances is measured in terms of obtaining practical skills, and these are privileged over the developing and operationalising of theoretical knowledge, which remains the 'property' of the qualified staff. The demand for practical, concrete skills; and the way in which nursing is defined by students as primarily manual labour are key features of their accounts.

Melia points to the tension between the expectation of nursing *behaviour* acquired by students in the school of nursing; and their negotiation of the practical exigencies of ward life. Students adopt the culture of *work* in a highly pragmatic way, quickly learning to conform to the practical demands made of them by qualified staff:

Student:

SEN's<sup>8</sup> I get on with really well because they are in with the patients. Staff nurses I don't know, some of them I get on with really well but not on a working basis. They are giving the orders, you run to them for help and that's it (...) When you first go on the ward they are really helpful, but if you don't progress as quickly as they think you should, they can turn round and be really nasty. (1987:71)

The division and regulation of labour in which the student nurse is set is

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<sup>8</sup>State Enrolled Nurses. This is the equivalent of the 'practical' nurse in the US.



organised around the operationalisation of a hierarchy of skills and knowledges: but clearly, the student is only part of a chain of subordination in which his or her qualified superiors are also located. The relative autonomy of the qualified nurse to exercise discretion about the self-allocation of more rewarding tasks is tempered by their own subordination to both managerial bureaucracy, and to the greater expertise and knowledge of medical professionals, who in turn regulate and direct their labour.<sup>9</sup> However, within this hierarchy of power and expertise, the qualified nurse is able to 'cream off' tasks.

Student: Yes, and some of the trained staff they even prefer to be doing things like just making empty beds, rather than doing basic things like beds and bed baths; which is so wrong, because you always learn so much about the patient in intimate surroundings, you just get to know them so well (...) Maybe it's time we got back to basic, more basic nursing.

Melia: The status of it (...) a drug trolley is high status, washing somebody is not so good.

Student: *[Heavy with sarcasm]* Yes, anybody can do that, whereas only trained staff or two students can do drugs (...) I think things are a bit upside down. (1987:153)

The nurse training experienced by the student, then, is directed largely at the *reproduction of work*, rather than at the operationalising of theoretical knowledge: and it demands the pragmatic negotiation of a highly specific work culture. This work culture needs to be seen as articulated to the organisational context in which work takes place, and as the field in which professional ideologies, practices of care, and the demands made on the nurse by management are negotiated. Casey and Dunkerley (1984), have emphasised the importance of work cultures within organisations, as the terrain on which organisational and technical change are negotiated on a collective basis. They

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<sup>9</sup>Hughes (1988) has argued that it is important not to see these inequalities of power and expertise in an over-deterministic way, and has pointed to the way in which nurses in a hospital casualty department are able to 'lead' medical staff into certain courses of action. Field's (1984) study of an acute medical ward also shows the extent to which qualified nurses are able to negotiate the taking over of some tasks and responsibilities normally in the domain of medical staff, so developing wider fields of autonomy and discretion.

argue that work cultures are organisation-specific, referring to the unique configuration of: 'norms, values, beliefs (...) that characterise the manner in which groups and individuals combine to get things done' (1984:141). Although there is considerable evidence to suggest that the culture of nursing is cohesive and solidaristic at the level of work groups, it is important to note that nursing is a heterogeneous occupational category: the student culture which Melia describes, in which first year students are instructed in basic tasks by second years, and so on, may contain quite different emphases to that of qualified nurses. It could be argued that the cultural fixation on physical tasks which students presented in Melia's study is a way of making sense of the fragmented and mobile experience of work, and also of coping with the constant production and termination of work relationships with staff and patients.

#### **2.4.2. Work culture and interaction**

So far, I have suggested that the organisational context, and occupational cultures, (in which formal practices are negotiated, and professional and managerial ideologies circulate), form the general structure in which interaction, or contact, takes place: but, of course, this structure is not negotiated by the nurse at a general or theoretical level, but rather in the concrete or 'lived' experience of the ward. It is in these local conditions that different forms of contact are permitted or inhibited.

Melia (1981), shows that nursing work is presented to students in the form of set of routines, and that the students themselves define 'work' through a focus on its physical activities. Here, the culture of the ward is one which is constituted around 'pulling one's weight' and 'getting through the work'. This definition is one which is generated through engaging with existing patterns of social organisation on the ward, where 'looking busy' creates an 'atmosphere of activity and efficiency'. Melia points to an attitude that 'nursing is hard and heavy work', embodied in an 'elaborate system of moral pressure and social

control'.<sup>10</sup> The presentation of nursing work as physical, domestic labour is clearly discordant with ideologies of professionalism; but it also generates real barriers to the development of the therapeutic relationship if talking to patients indicates a *lack of work*. Melia argues:

- That students are placed under stress if the patient wants to talk, while they are under pressure to 'get the work done'.
- If talking to patients is only valid once the 'work' is done, then the possibility of realising individual patient care becomes remote.

In this context the activities of students are directed by local management – the ward sister, and senior nurses – and students negotiate these immediate conditions on a pragmatic basis, recognising that contact with patients is organised around the routine tasks that they were assigned. Some students indicated that their supervisors 'allowed' or 'encouraged' them to talk to patients, and the language used here is organised around the permissive action of the charge nurse and indicates the degree of control involved.

The charge nurse has a crucial role in setting the parameters of contact between staff and patient, because through their management of the routine of the ward charge nurses define the possible activities of their staff. Where the form that this management control takes militates against contact, the situation can become very difficult for junior staff, as Knight and Field (1981), and Melia (1981; 1987), have shown.

Both of these studies centre on units in which terminal care takes place, and in which tensions between 'work' and 'contact' are exacerbated by problems of

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<sup>10</sup> This provides a compelling explanation for the very limited forms of interaction which some of the more comprehensive studies of nurse-patient communications – notably Macleod Clark (1982) – have revealed. In the face of video and audio recording of their activities it might be expected that nurses would delimit interactions and get on with formally defined nursing tasks, rather than entering into relatively lengthy conversations with patients. A further consideration here is the need for privacy where conversations which involve the patient's intimate needs are undertaken. A respect for the confidentiality of these interactions may have inhibited nurses' action – in view of the surveillance to which Macleod Clark subjected her population.

*disclosure and awareness.*<sup>11</sup> What, and how much to tell the dying patient about their condition is a major problem for nurses – especially in the UK, where decisions about disclosure belong to the attending doctor. Much of the literature about disclosure, in consequence, addresses the attitudes and preferences of doctors (Scheff, 1963; Cartwright *et al*, 1973; Ward, 1974). Knight and Field argue that failure to disclose persists for a number of reasons:

physicians and nurses claim that 'not telling' protects the patient from depression and anxiety. There may be genuine uncertainty with regard to both outcome and/or the time of death. Not telling protects physicians and nurses from becoming too closely implicated in the patients dying and so they can maintain the pretence of 'everything as normal' and not get involved in the handling of death. Finally the work routine of the ward may become disrupted by the disclosure of impending death.(1981:223)

McIntosh (1974) found that nurses shared this perspective of non-disclosure, (although more recent work throws this into doubt, see Field 1984, for example), and that this shared set of values meant that conflict did not emerge between medical and nursing staff.

#### 2.4.3. Two case studies

Knight and Field (1981) observed a 'typical acute surgical ward' on which the majority of admissions were for cancer. The layout of the ward meant that heavily sedated and terminal patients could be isolated from the rest of the ward, either in a six bed bay, or in three single rooms. Ward 7 was not a terminal or hospice ward, and neither patients nor staff expected malignancies to be fatal. The ward was short of qualified staff and relied on junior and student nurses to carry out the bulk of nursing tasks, while the sister and senior nurses undertook ward administration and management.

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<sup>11</sup> An extensive discussion of awareness and awareness contexts may be found in Glaser and Strauss (1965a; 1965b); Strauss *et al* have also presented (1968) a comprehensive case history approach to these problems in the clinical context. Kubler-Ross (1970) has suggested that awareness might involve discrete stages of personal response from the patient.

On Ward 7 communications were poor. Medical staff maintained an 'aloofness' with all except the nursing sister - who became the channel for medical instructions and information to other nurses. However, the sister was seen as a 'battle-axe' by junior staff, who had frequent unpleasant encounters with her. Junior staff were not permitted to enter the ward office as a refuge from their work, which was constituted around physical labour and care.

Once patients were identified as terminal medical staff tended to spend less time with them while on ward rounds, and patients became anxious in the face of this apparent withdrawal - construing it as a tacit 'cue' about their condition - and this led to them asking nurses quite problematic questions. On Ward 7, a medically driven policy of closed disclosure, ie. not telling the patient about their prognosis, was carried out. Despite this, only five out of the forty terminal patients admitted to the ward during the period in which it was studied were completely unaware of their condition. The suspicions of patients created a further tension in contact. Poor communication between medical staff, ward sister, and junior nurses, meant that information was not readily available to patients; and junior nurses were severely restricted in what they were able, or allowed to tell them.

Knight and Field argue that the 'general principal' underlying patient-staff communication was that staff were superior by virtue of their expert knowledge and status, and that this was established unproblematically with most new patients. The provision of information to patients was mainly restricted to technical matters about care, and a set of routines acted to manage communication in one of three main ways:

First, it ensured consistency in the sort of information which a patient or patients with similar conditions received from any member of staff. Secondly, doctors were absolved from having to take decisions in specific cases. Their responses to questions were generally routinised irrespective of the character of the patient. Thirdly, it ensured that members of staff did not come into conflict over what patients should be told. In particular it was clearly understood that patients should not be given unfavourable information about their condition. (1981:225)

Because of the limited information available to them, junior nurses rarely knew how much detail the patient had about their condition:

This situation became impossible when patients would say, 'I know I've got cancer': the nurse was not to know whether the patient was 'trying her out' and waiting for her reaction. On the other hand the patient may have genuinely been told by his relatives. This aspect caused further friction between the medical and nursing staff. (1981:226)

Similar responses are recorded by Melia (1981). Nurses' own definitions of the patient's clinical trajectory could also cause problems, as the nurse becoming more attentive to comfort and condition was itself a cue to them about prognoses.

The conditions in which contact between nurses and patients took place on Ward 7 were primarily ones of constraint, in which nurses were involved in evading specific forms of contact – in which they would be questioned about prognoses – while still maintaining good personal relationships with patients. Despite these constraints it was normal for junior nurses to build up close bonds with patients. These were not just 'work' relationships, organised around personal familiarity, but *friendships* in which patients confided in the junior nurse.

These 'friendships' became extraordinarily demanding for the nurse in cases where patients were fatally ill – and where the patient was being reassured about their recovery, while he or she was attempting to come to terms with almost daily deterioration. Dealing with patients confusion in these circumstances was distressing for nurses who felt that they were lying to patients with whom they had a personal relationship founded on trust.

On Ward 7, the impact of local patterns of management and medical protocols were combined with a physical definition of nursing work. This generated problems in the development of relationships between nurse and patient. Furthermore, the contradictions and conflicts created by protocols about non-disclosure, and the general poverty of communication between staff on the ward, generated highly stressful relationships with patients for junior nurses.

Field (1984), studied another acute surgical ward. This was a ward with open disclosure, and a less strictly defined division of labour. It was run along team nursing lines, in which charge of the ward was rotated through qualified and experienced staff. Communications between medical staff and nurses were



good, where problems arose the ward sister took an active role in negotiating with medical staff: and also communicated the feelings of nurses and patients to them. Because communications were good, and problems were quickly resolved through the commitment of the sister and qualified nurses, the matter of disclosure was largely delegated to them. Even so, the sister made a point of negotiating the way in which this would be conducted with medical staff to maintain their involvement.<sup>12</sup>

On Ward 6, an entirely different management practice was employed. The Nursing Process was fully in force and the staff were committed to it; and because of the ward policy of open disclosure, the tensions and contradictions that existed for junior nurses on Ward 7 were largely absent. The majority of Field's respondents on Ward 6 expressed a preference for open disclosure – although it created problems of its own – and in these cases the sister acted as a mediator, negotiating the transition to 'open awareness' when other staff were unable to do so.

Nurses were committed to establishing a relationship with the patient and to providing 'total nursing care'. Respondents recognised that the first stages of disclosure and the impact that this had on their relationship with the patient created initial difficulties:

Respondent:

sometimes I find it difficult if they don't know they're dying (...) the time when they first get to know. I find that bit difficult still. It's all right when they know. It's all right when they don't know. It's the in-between bit when they're getting to know and they're asking some difficult questions. (1984:64)

Where closed disclosure allows the maintenance of an emotional detachment

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<sup>12</sup> It must be emphasised that this delegation of disclosure is extremely rare. Normally, medical staff maintain control over the disclosure of diagnoses



or distance,<sup>13</sup> the strong preference for open disclosure displayed by almost all of Field's respondents on Ward 6 made some emotional involvement inevitable. Qualified staff did not see this as problematic:

Respondent;

I think that you should get involved with all patients. I know when you start your nursing they say to you "oh don't get involved with your patients" but I think that its difficult to nurse someone if you're not really getting to know them. And when in fact we do the Nursing Process on here everything's a lot more personal. We're on first name terms with a patient, so you do get to know them. (1984:65)

On Ward 6 nurses were implicated in a high degree of 'emotional' involvement with patients, and this generated powerful bonds between them. However, this was one outcome of a clearly defined and coherent ideology of total patient care, and the organisational style that sprang from this. The Nursing Process was used, and nurses had unambiguous responsibilities for individual patients. Within this they had some measure of autonomy to plan and act out individual patterns of care, which allowed them to put into practice their ideas of what *really* constituted nursing work. The small size of the unit, and the small number of staff working in it meant that staff were able to build up relationships with each other, which offered peer support when patients died. A relaxation of the hierarchy of nursing grades contributed much to this, and the role of the ward sister was crucial to creating the ward ethos which made this possible.

Both Knight and Field (1981) and Field (1984; 1989) emphasise the role of the charge nurse in defining, directing and regulating nursing work, and in maintaining a particular configuration of social relations on the ward, and this

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<sup>13</sup> I examine the question of 'involvement' in chapter 8.

has been confirmed by Peterson (1988) in the United States,<sup>14</sup> and Whelan (1988) in the UK. Although line management plays an important part here, it is important to balance this against the way in which any form of managerial leadership requires the consent and support of staff to be successful. Moreover, as Reissetter and Thomas (1986) have argued, nursing work may not correspond directly to the definitions and attitudes of practitioners on the ward: and as Gray (1977) reports, in her study nurses recognised the importance of patients' individuality, but this did not lead to the definition of problems connected with the individual needs of specific patients.

## 2.5. Nurse-patient interaction: moral imperatives and ambiguous expectations

At the beginning of this chapter, I indicated that my intention was explore two specific research perspectives or themes within the literature.

The first of these, represented by Stockwell (1972), or by Keck and Walther (1977), involves a *technocratic* perspective. Within it, nurse-patient interactions are seen essentially as technical problems of practice and are investigated in terms of actions, attitudes and behaviours which contribute to nurses' productivity and to organisational effectiveness. These studies tend (a) to have their basis in theories or models of nursing, and (b) to employ extensive research methods.

In the technocratic research perspective, interactions between nurses and patients are typified as being routinised and strictly controlled, and from this it is easy to infer that the relationship between participants is itself highly superficial. In operating at this level, such accounts fail to look beyond the

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<sup>14</sup>An important question needs to be considered here concerning the extent to which it is reasonable to compare research undertaken within the US health care system and that undertaken within the UK. Clearly there are general similarities in terms of research outcomes, but their contextual basis needs to be considered. It has been suggested to me by Keith Sharp (personal communication) that one reason for the delimitation of nurse-patient communication in the US might be due to nurses' reluctance to advise, inform or counsel because of the possibilities of litigation consequent upon the provision of unwelcome or incorrect information. It may well be that the volume of legal action in respect of malpractice, and the terms of malpractice insurance have an impact on nursing practice in the US in ways which we have not experienced in the UK. Similarly, quality assurance practice in the US is quite different to that undertaken in the UK and this will have a more concrete impact on the conduct of encounters between nurses and patients. The spatial arrangement of US hospitals – and the predominance of single or double rooms – may also mitigate against casual contact: while the nurse is away from the central nursing station he or she will be out of contact with other patients, and unavailable in an emergency.

immediate actions of the nurse and address the ways in which they are constituted through social processes. In concentrating on the dynamics or mechanics of individual encounters, the meanings and understandings attributed to them by participants are neglected, and in consequence these accounts generate a range of data about the ways in which communicative action by nurses departs from the prescriptive demands of nursing theory.

The second perspective, represented by Knight and Field (1981), or by Peterson (1988) is *contextual* in focus. This does make the shift from individual action to the social organisation in which it is set, and tends (a) to have its basis in sociological or social psychological theory, and (b) to employ intensive research methods. When we come to look at contextual research, it is clear that some nurses are involved in closely bonded relationships with some patients even when dyadic interaction between them is apparently routinised and superficial.

This shift from individual action to its social definition and organisation is accomplished by operating outside of ideas about what practice *should* be like, and by directing attention to the social organisation of the workplace and the way in which this leads to specific forms of encounter between nurses and patients. In this approach, the understandings of nurses and the meanings which they attribute to their action are much more fully apprehended. Even so, this simply moves the problem one or two steps up the line: relocating problems of nursing practice from the individual to the collective organisation of nursing at a local level, and focusing on negotiation and legitimation within or between different professional groups and patients.

Of course, both research perspectives operate from a critical concern with the content and quality of the nurse-patient relationship: underlying what Kelly and May (1982:147) have characterised as the 'conviction that differential interpersonal treatment might count for differential rates of recovery'. This is partially consequent on the way in which nursing theory has come to embody what Lasch (1979:7) has called the 'therapeutic sensibility' and to characterise the patient as in some senses *idiosyncratic*, and to recognise them as more than a constellation of physiological symptoms demanding remedial or restorative treatment. This gradual move away from a simple medical model of treatment, (dependent on the diagnostic expertise of doctors), towards the development of theories of nursing care incorporating notions of the patient

individualised by social, cultural and psychosocial characteristics – involves the manufacture, or 'fabrication' of new definitions and objectives for nurse-patient relationships (Armstrong, 1983a).

### 2.5.1. The knowledge base of nursing and the individualisation of patient care

In the transition from nursing as an occupation constructed around ideologies of vocational service, to nursing as a professionalising occupation informed by expert knowledge; not only does the ideological basis of the occupation undergo radical change (Williams 1974), but attempts are made to construct new bodies of knowledge to form the basis of professional identity.<sup>15</sup> Gow (1982) has argued that in nursing these new bodies of knowledge are organised around two polar extremes, or 'clusters':

- Professional identity based on developing a distinctive body of knowledge and professional expertise from which equivalence as scientific colleagues to doctors could be constructed. Or:
- Professional identity as expressive specialists, derived from the development of a distinctive body of knowledge of psychosocial dynamics, and skills in therapeutic relationships.

Clearly, contending claims about the knowledge base of nursing have an impact on those made about its definition and objectives. It must be emphasised at this point that – among academic nurses at least – there are fundamental disagreements about this, as the proliferation of elaborate theories and models of nursing since the 1950s bears witness. Although disunity in the theorising segment of nursing is apparently distant from ward practice it does have an effect from two points of entry: nurse education and nursing research.

Non-vocational concepts of nursing based on theories of patient

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<sup>15</sup> There is no evidence that this transition is complete in any meaningful sense, as Dingwall *et al* (1988) and Melia (1987) have pointed out. The ambiguous professional status of nursing inevitably has an impact on practitioners perceptions of what they do, and Simpson *et al* (1979) and others have pointed to the romanticism of the student and newly trained nurse as a source of role conflict.



self-maximisation through the intervention and guidance of the nurse originated in engagement with Parsons (1952) concept of the 'sick role' - in which the patient is regarded as an essentially passive recipient of health care - and with the social psychology of writers like Abraham Maslow. We can find this theoretical material represented in the work of Orem (1959), and Rogers (1961). The theme is developed through notions of the nurse as facilitator and co-ordinator of patient care and recovery (Weidenbach, 1964) through to support and participation in the process of patient self-care, and self-realisation (Levine, 1969). The theorisation and retheorisation of nursing practice finds its culmination in contemporary models of the Nursing Process, (see for example, Mariner 1979; and Binnie *et al*, 1984). Directed at the individualised planning, implementation, and evaluation of nursing care, the Nursing Process is intended to offer the basis of a system of nursing which emphasises a collaborative response to the communicative and psychosocial needs of the patient, alongside medical models of treatment. Dingwall *et al* (1988) have argued that this establishes a disciplinary focus on both the patient and the nurse; and they argue that the individualisation of patient care effectively ensures that 'personal objectives are confused with those of the occupation or organisation' (1988:220).

Trends towards individualised care are reflected in a range of educational *rhetoric* focusing on the development of interpersonal skills within the individual nurse: either in the form of prescriptive accounts of the nurse-patient relationship (for example, Purtillo, 1984); or as handbooks of 'communications skills', (for example, French, 1984; Bradley and Edinberg, 1982; Porritt, 1984; and Weaver Duldt *et al*, 1984). The development over time of a literature about skills in communication, and of a theoretical literature about 'relationships' between nurse and patient forms the intimate connection between theorisation, research and practice - but is directed largely at the student nurse - locating interaction as an educational problem to be resolved through curricular development, as Kelly and May (1982), have pointed out.

At the level of professional and educational rhetoric the privileged status of the nurse-patient relationship is organised through a prescriptive discourse about 'social skills', and this is founded on a number of assumptions. First, these skills are particularised within the orbit of the personal responsibility of the individual nurse, and this is achieved through the isolation and redefinition of social accomplishments as technical skills and practices which may be

improved or brought into being by curricular development and in-service education. The implication that delimited forms of encounter are essentially an educational problem neglects both the meanings that nurses attribute to them, and their understanding of the conditions in which they take place – in which constraining factors operate to inhibit nurses from meeting the moral imperatives of a prescriptive theoretical discourse.

Second, the particularisation of responsibility for the production of therapeutic interactions with patients within the sphere of individual nurses assumes a high degree of personal autonomy, and as Dingwall *et al* (1988) point out, a private relationship between practitioner and patient. But this neglects the way in which nursing is actually a collective accomplishment, undertaken by groups of people working together to provide medical care which may be decided upon by other professionals. The degree of real discretion available to the nurse about how interactions are related to practical activities, and about what form they should take, may be very limited. This is especially so for student nurses who are, as Melia (1981) notes, subject to a practical evaluation of their work – but who on many wards are the members of staff who spend most time in contact with patients: and this is compellingly revealed in the contrast between studies presented by Knight and Field (1981) and Field (1984). In the latter study it is interesting to note that the charge nurse had made efforts to expand the autonomy of ward staff and to organise the ward in ways which emphasised this.

Third, underlying the concentration on technical and isolable features of the encounter between nurse and patient, (which form the basis of technocratic accounts of nurse-patient interaction), is the way in which the combination of professional ideology and privileged knowledges are deployed to dissect the patient according to signs, symptoms, and pathology. Through this the patient is reconstituted as a set of problems disassociated from their context: and such a dislocation and reconstitution is a feature of *all* medical discourses. Armstrong (1982;1983b) has pointed to the way in which discourse about the patient as an 'individual' or as 'idiosyncratic' is not simply a device for exploring problematic elements, but has the effect of constituting medical relationships as problematic in themselves.

In this way, the whole range of responses to the patient by the nurse are rendered problematic. Through the historical constitution and reconstitution of

patients 'needs' and psychosocial problems, a technical vocabulary emerges containing new signs and symptoms. However, the aetiology of these new problems remains disconnected from the contextual features implicated in their production. Hence, discourse about patient anxiety is directed at the nurse's failure to address and resolve it, rather than at the way in which a response to the patient's difficulties may also be impaired or constrained by medical procedures, institutions and relationships. In consequence, the encounter between nurse and patient is recast as a diagnostic moment in which problematic fears and anxieties, desires and needs, are to be identified and resolved. In the theorisation of this diagnostic moment interaction and relationship are redefined as social encounters and are given a new dimension as technologies of treatment. However, the focus on interaction as purposive, and on therapeutic relationships as its intended outcome, has led to an emphasis on the nurse-patient relationship as a set of formal practices, directed at the patient and delivered by the nurse.

A prescriptive discourse about professional action, the definition of nurse-patient interaction as a therapeutic instrument, and the moral imperatives which underpin this, implicitly locate the failure of nurses to generate therapeutic relationships in the sphere of the individual, precisely the level at which it may not be addressed and resolved. This sets the agenda for, and is buttressed by, a technocratic research perspective on these encounters. From this perspective, the focus on patient anxiety, on their demand for information, or on evidence of 'consumer dissatisfaction' with interpersonal relations with health professionals – as isolable features of their *condition* – opens up nurse-patient interaction as a therapeutic technology through which treatment may be delivered. The effect of this is the generation of data about nurses' *productivity* and its immediate impediments. The modelled, prescriptive construction of the encounter between nurse and patient, treated in the form of an educational problem, involves the isolation and definition of technical skills and tactics. Located firmly in the domain of the *professional*, these are organised around the expert knowledge, professional objectivity, problem solving capacity and affective neutrality of the nurse. However, presented in the form of 'ideal types' of encounter, nurse-patient interaction is apprehended at the level of simple, interpersonal contact. This dislocates it from the institutional, organisational and cultural contexts in which it takes place, and from the complex arrangement of power relations mediated within them. Beyond the social practices of the immediate encounter participants socially



construct meanings for the discourses and behaviours manifested within it, in relation to the complex matrix of social relations and processes in which they are historically implicated.

In a sense, the medical interview has been relocated and reconstituted as the nursing interview; and Macleod Clark's (1982) study, employing content analysis of nurse-patient interaction, presents a good example of this approach. Macleod Clark focuses on the failure of nurses to respond to the psychosocial, neglecting the possibility of nurses being able to explain the way in which they deploy conversational tactics to limit interactions in terms of their real discretion and knowledge about the context of encounters with patients. In Bond (1978), nurses' explanations of the limitation of these encounters are apprehended, but again, this study uses a prescriptive discourse as its benchmark. The central difficulty for a technocratic perspective, here, is that it addresses its efforts precisely at the point at which constraints on nurse-patient interaction cannot be resolved – in that it focuses on individual action – rather than on its social organisation.

## **2.5.2. Contrasting 'projects' in the study of nurse-patient communications**

Rhetoric connected to the theorisation of nursing, as we have seen, is presented in a prescriptive discourse about professional skills, and in the form of a body of theoretical knowledge organised separately from medical expertise about treatment. Technocratic research into nurse-patient interaction and relationships is profoundly influenced by this, but it would be wrong to suggest that there is a single source of such research and that this is located in changing nursing theory and processes of professionalisation. These are only partial explanations of the constitution of interaction as a research problem. In fact, these research accounts are intimately linked to the development of distinctive spheres of interest within the social sciences and draw heavily on a positivist tradition within them. This operates at two levels: first in the assumption that different aspects of interaction can be measured, variables identified and causal relationships established; and second that the research effort itself is a source of institutional and professional change. Hence, in Kagan (1985), we find one of many detailed discussions about the extent to which nurses and nurse managers in what Melia (1987) has characterised as the 'service' segment of nursing have been exposed to, and taken up, the

results of 'nursing research'.

Historically, as Armstrong (1982) has asserted, interest in medical communications has its source in prewar medical concerns about compliance and authority, and patient default and dissatisfaction. These medical concerns became organised around a central assumption that they were derived from a failure in communication between doctor and patient. Armstrong argues that the emergence of patients' anxieties about the medicalisation of everyday problems was reconstructed by the medical profession in terms of their capacity to communicate authoritatively, and so obtain compliance. Furthermore, the emphasis on communicating the authority of medical knowledge to the patient was itself a 'mode of obtaining obedience and confidence' (1982:112).

The history of the nurse-patient relationship as a research problem is also intimately connected with concern directed at doctor-patient relationships. In the United States studies of the professional socialisation of the student nurse emerge in direct and explicit relation to studies of the professional socialisation of medical students, largely through the work of qualitative sociologists - Everett Hughes, Becker, Strauss, Glaser, and Jeanne Quint. Macleod Clark (1985) has observed that in the UK initial interest in nurse-patient interaction was arrived at through a range of studies directed at patient satisfaction and dissatisfaction with aspects of hospital care. A consistent feature of such surveys has been the implication of both doctors and nurses in a failure to provide patients with adequate information about their condition, and about the practices and procedures of treatment carried out on them, (see McGhee, 1961; Cartwright, 1964; Hugh-Jones *et al*, 1964; among others).

This focus on communication to patients, and their apparent demand for information has led to a range of what Macleod Clark has characterised as 'intervention studies' which demonstrated the impact of specific forms of pre and post-operative information on patient stress and anxiety. The relationship between specified information and patient satisfaction is by no means clear cut, however. Although a number of studies (Johnson, 1971; Johnson *et al*, 1973; Hayward, 1975) have demonstrated an effect, this varies according to the individual patient (Wilson-Barnett, 1978) and the 'communication skills' of the nurse (Davis, 1981). What also remains in doubt is whether the specific forms of informative practices employed in this form of study are those required by

patients, or whether other kinds of practice would be equally beneficial. There is good evidence, for example, that impersonality and lack of continuity of care are a major source of 'consumer dissatisfaction' (Evans, 1985).

The next rank of studies identified by Macleod Clark are characterised as 'observation studies'. These have described in detail the limitations of practices of interaction on the ward, often in a quantitative form. At the same time, qualitative accounts of nursing practice have brought into the foreground a range of cultural and organisational inhibitors of nurse-patient interaction. These have led to a range of interesting questions about the ways in which nursing work is defined and organised, and how nurses' encounters with patients are contextually located at the juncture of nursing *work* and nursing *behaviour* – that is, at the point of tension between the specified material tasks and practices that make up the business of nursing care – and the cultural or subcultural discourses and behaviours through which nurses order their occupational world.

Where discussion about the doctor-patient relationship has largely been undertaken by social scientists concerned with professional power relations and dominance; and the modes of discourse and behaviour consequent on these (for example, Freidson, 1964 etc); and with the organisation of professional divisions of labour (Turner, 1987; Rueschemeyer, 1986, and others): research into nurse-patient relationships has largely been the province of nurses themselves, whether located in either academic, or service 'segments'.

This has tended to follow one of a number of courses: interest in professional socialisation (Quint, 1967; Simpson *et al*, 1979); a concern directed at 'attitudes' (for example, Stoller, 1980); and a more recent body of research directed at apprehending the dynamics of the dyadic encounter between nurse and patient through technocratic analyses. In parallel to these have emerged what I have characterised as *contextual* accounts: these studies have emphasised the complex division of labour *within* nursing, and the limited sphere of autonomy and discretion nurses have in relating to both patients and other health professionals. Yet as Stein (1967), Hughes (1988), Kelly and May (1982), and Field (1984) have all pointed out in different contexts, it is important not to over-determine the problematic nature of the power relations involved in this, but to see doctors, patients and nurses as interactive (if unequal) participants in the construction of encounters and relationships, and to locate this in terms

of negotiated and legitimated social relations.

## 2.6. Implications for research practice

In this chapter, I have pointed to a number of ways in which the interpersonal relationship between nurse and patient has come to be constituted as a the site of a set of problems; and the ways in which these problems have been investigated and charted in terms of their dimensions and sources. This is by no means an exhaustive account, but is presented for two reasons: firstly, to describe the results of specific research enterprises; and secondly, to establish the limits of contending research perspectives and identify some of the problems associated with them.

Throughout the chapter, one of my central concerns has been to emphasise the value of a sociological perspective in exploring interactions and relationships between nurses and patients – in contrast with the very limited explanatory powers of theories of nursing. In fact, how relationships, events, practices and discourses may be theoretically apprehended is a critical problem for nursing research, as part of an academic discipline that is expected to contribute to practice, as I have intimated elsewhere (May, 1990). As it stands, nursing theory is unable to offer a coherent framework through which connections may be made between the actions and attitudes of individual nurses; the social organisation and context of nursing practice; and the broader matrix of social processes, structures and power relations that define nursing as an occupation, determine the division of labour in health care, generate shifts in occupations and technological innovation, and which frame the political economy of health care at a more general level.

Clearly, sociological theory and research perspectives have a great deal to offer here, but beyond this, some sociological models of theory building also have much relevance to theory development in nursing, and these may be deployed in ways that make concrete connections between research practice and theory development.

Perhaps the most appealing possibility here is that of building theory up from empirical work in substantive areas of research, using an inductive approach to theory development of the sort developed by Glaser and Strauss *et al* (1964; 1967; 1978). Melia and Fawcett (1988) have recently pointed to the potential of

this form of theoretical enterprise for nursing. Within it, empirical research into specific contexts generates what Glaser and Strauss have characterised as *substantive* theory, and this may be developed – as the body of substantive theory grows – into *formal* theory which transcends specific contexts and which allows the conceptualisation of more general social relations, practices and processes across a range of settings.<sup>16</sup>

Research practice based on the inductive method offered by Glaser and Strauss forms the basis of much of the contextually oriented research discussed in this chapter, and there are clear benefits for researchers in using such an approach. Within it, the theoretical conclusions drawn from fieldwork are empirically grounded, as opposed to the use of empirical work to test grand theory. The formal theoretical categories that ultimately emerge from such work also offer important benefits to nursing theorists, in that they have a direct relation to the 'realities' of nursing as experienced by practitioners and are consequently accessible to them – as the intended beneficiaries of nursing theory and research.

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<sup>16</sup>An excellent example of this is Glaser and Strauss's own work on *status passage* (1965a). This has recently been taken up by Fox (1989), who has argued that it might form the basis for a much more holistic sociology of health and illness.



## CHAPTER 3

## RESEARCH METHOD: THEORETICAL BASE

**3.1. Introduction**

In the chapter which follows I wish to locate this study in an interpretive, or subjectivist theoretical framework for sociological research. In this chapter, I outline some of the epistemological and methodological issues that this position involves. I do not intend to attempt to give a comprehensive account of subjectivist sociological theory and practice. Instead, my objective is more limited, and the chapter is organised around the discussion of two main problems.

1. The notion of *verstehen*, ie. the interpretive apprehension of actors' experience of social action, and its meanings.
2. The interview as the site of data collection in interpretive research, and the limits that must be placed on claims made about the relation between data and the 'reality' of subjects' experience.

The aim of this study was to explore the experience of nursing the terminally ill and dying, the ways in which nurses understood and defined their relationships with these patients, and the meanings which nurses attached to them. The data on which it is founded was obtained through semi-structured interviews with nurses, and the purpose of this chapter is to make the connection between this 'data' and the ways in which accounts are constituted, reproduced and interpreted.

**3.2. Contending perspectives on methodology**

In the initial stages of the study, concurrent with the development of the research question, a number of theoretical frameworks and methodological strategies were considered. Following Sayer (1984), these fall into two main categories – *intensive* and *extensive* – which correspond approximately to the more conventional distinction between qualitative and quantitative methods.

Historically, as Husbands (1981) and many others have pointed out, discourse within the social sciences about research methods has been marked by conflict and division between proponents of what Wilson (1970) has characterised as a *normative* perspective, (representing a positivist-quantitative methodological approach); and proponents of an interpretive and qualitative perspective. This contest cannot be reduced to any simple disagreement about ways of handling data, but involves more fundamental debate at an epistemological level, about the ways in which ideas about the social world influence the assumptions through which research questions themselves are framed. In this sense, the conventional proposition that method must be appropriate to research question is adequate only if it is recognised that both are theory laden and theory dependent. In other words, the relationship between question and method is not a simple mechanical one, since both are informed by a theoretical vocabulary which constitutes the problem with which they are intended to engage.<sup>1</sup> Data, then, cannot be considered to be pre-given or independent of question and method, but is consequent on theoretical cosmologies which specify what it *is* and what it can be held to *mean*.

In locating this study within an interpretive paradigm, rather than in its alternatives, other ways of apprehending the social world are neither denied nor disregarded. The general merits of other theoretical cosmologies, or of other methods are not at issue. However, methods texts, (for example, Silverman, 1985), increasingly emphasise that qualitative and quantitative methods have a potentially complementary effect in illuminating different aspects of the same problem. I have tried to demonstrate this in Chapter 2, by pointing to the way in which extensive accounts bring into the foreground information about the limits of verbal interaction, while qualitative contextual accounts explore the meanings and significances of the processes and practices which take place within those limits. The welcome emphasis on complementary methods, however, cannot dispose of the more fundamental problem of profoundly divergent and apparently incommensurable theoretical cosmologies, and the methodological strategies consequent upon them. Nor can it resolve the more fundamental debate about the nature of the social

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<sup>1</sup>This can be seen clearly in Sayer's (1984:222) summary of the distinctions between intensive and extensive approaches.



sciences that takes place between positivists and non-positivists in all of their different forms. These are not questions which can be dealt with adequately in this chapter: but what can be done, throughout the study, is to render the theoretical assumptions on which it is founded accessible to the critical gaze of the reader.

### 3.3. The subjectivist frame of reference

The subjectivist frame of reference discussed in this chapter has its sources in Husserl's phenomenological critique of positivist social science. This distinctive approach enters the sociological arena through Schutz's attempts to develop and reconstruct Weber's concept of *verstehen*, through which he proposed a sociological method to apprehend the subjective meaning and experience of social action.<sup>2</sup>

#### 3.3.1. Reconstructing the Weberian project: *verstehen*

Husserl rejected the conventional basis of the positivist project: that human action could be seen as 'objective' social phenomena, and that the empirical observation of these could reveal 'natural' laws governing them. The replication of the methods and world-view of the natural sciences within positivism, Husserl argued, involved a distorting *reification*, (in which ideas about the nature of reality are conflated with reality itself). His phenomenological alternative attempted to avoid this by recasting the basis of social scientific enquiry: instead of directing this at the nature of reality (on the basis that it can be objectively known), Husserl asserted that the social and material world is 'known' through constitutive processes. Social reality, in this perspective, is the outcome of the negotiation of these processes in the subjective consciousness of the actor.

Husserl's alternative question is cast in a form which emphasises this subjectivity by asking, 'how does reality come to be constituted as a known object by mental processes?' (Johnson *et al*, 1984:78). The explicit intention

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<sup>2</sup>As Phillipson (1972) points out, phenomenology is not a unitary body of thought: there are variant phenomenologies in the same way that there is no single 'sociology'.

here is to engage with the processes through which social reality is constituted by the actor in the process of 'knowing' it and with the ways in which this is understood and experienced. This approach was taken up by Schutz in the critical development of Weber's notion of *verstehen*, in which its perspective is redirected. Weber was concerned to examine social events through an analysis of their subjective meaning and significance within the experience of the actor. While attaching considerable importance to this procedure, and arguing that 'subjective understanding is the special characteristic of social knowledge' (1971:137), he failed to develop the concept of *verstehen* in a form which disassociated it from a programme of empirical observation. This means that in Weber's account there is a tension between subjective understanding by the actor, and procedures for the empirical observation and verification of these by the 'objective' observer. To resolve this tension, Schutz had to develop the concept of *verstehen* in a radically new form.

Weber's notion of *verstehen* is that of a form of common-sense knowledge and understanding held by the actor. It forms a tacit cognitive framework in which social experience and action are interpreted by the subject. A methodology which attempts to apprehend this demands analytical categories through which the subjective understanding of the actor can be interrogated. However, the tension between *verstehen* and objectification in Weber's account is problematic because, as Bernstein (1976) and Johnson *et al* (1984) point out, from a phenomenological perspective, objective categories for observation must themselves be seen as having been subjectively created by other actors.

The methodological problem faced by Schutz, then, was to reconstruct Weber's notion of subjective meaning in a way which opened up its processual and interpretive form to external interrogation, but which was able to do so without collapsing into reified empiricism. This demanded the dislocation of *verstehen* from a programme of external observation, and its relocation in the realm of the intersubjective.

Dislocated from empirical observation, the social world is conceived as a set of emergent properties, the outcome of social accomplishments, and these are apprehended by the observer through a set of subject-subject relations as opposed to the conventional subject-object relations of positivist social science. A view of social reality as an ensemble of emergent properties, rather than as more or less determining essential structures and relations, also

demands a different notion of the relation between actor and action. Schutz achieved this by integrating some of the theoretical concerns of Dewey and Mead. In their pragmatist perspective, social order is the outcome not of the coercive determination of external essential agencies, (such as the state, or capital), but of collective and self regulation of a much more subtle form. This non-essentialist perspective revolves around the way in which actors interpret the possibilities for action and understand the world around them.

Through what Foucault has characterised as a regime of knowledge,<sup>3</sup> interpretive understanding establishes the parameters of potential social action, and its imaginative projection is held in check by the taken-for-granted spheres in which it is contextualised, experienced and 'known' by the actor. Schutz's emphasis on *intersubjectivity* is of central importance here. In the relation between subjects the social world is jointly constructed through interactive processes. The highly specific nature of the individual biography means that subject-subject relations are not organised around identical experience, but instead are generated in a process of 'reciprocal validation', (Schutz, 1971:166). In interaction the actor engages with a common stock of knowledge and discourse through which social reality is actively constructed and understood. This common stock enables relations, processes and events outside of the experience of the actor to be 'known' through their mediation and signification in discourse as *social facts*. *Verstehen*, in the form of common sense knowledge and typification of social reality is integral to the biography of the actor. It is, in a sense, the tool through which living-in-the-world is negotiated. The actor not only engages with individuated understanding, but also reflexively enters into the sphere of others.

This poses the question of how the actor proceeds to engage with this common stock of taken-for-granted knowledge: how is *verstehen* accomplished? Berger and Luckmann (1966) point to the process of socialisation as its source. Socialisation has to be seen as more than a passive process of acculturation, in which the actor absorbs social knowledge and 'learns' about appropriate and inappropriate modes of behaviour and discourse. At a higher level, socialisation involves the continuous interpretation of the

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<sup>3</sup>See Gordon, (1980)

social world, and the *sedimentation* of that interpretive knowledge within the consciousness of the actor. This is both explicit and implicit: what is initially 'strange' or 'enigmatic' to the actor demands reflexive interpretation through the medium of what is already 'known' before it enters the taken-for-granted in a constituted form. This interpretation through a developing and experiential cognitive framework forms the process through which the social world is objectified by the actor.

It must be emphasised that this common stock of socially constructed knowledge is not homogeneous, and nor is the actor's coming to know it an unproblematic linear progression. Instead, it is fragmented and interactive, involving constant adjustment in the face of the new. Moreover, apparently contradictory discourses and knowledges may be held concurrently by actors, each engaging with different spheres of their social experience.

*Verstehen* as a set of sedimented understandings and knowledges forms the basis, then, of a vocabulary or repertoire of discourse and action. This conventional knowledge is always provisional, in the sense that at each moment the actor is not simply located in space and time, but also in an historical relationship with the social world, mediated through intersubjective processes. The consequence of this is that the actor is confronted at each new 'moment' with social life in an emergent form that is amended at the point at which the actor engages with it.

### 3.3.2 Constraints on *verstehen*

The principal feature of Schutz's phenomenological perspective outlined in the preceding discussion is the priority that it gives to the subject's definition and apprehension of social reality. This emphasis has, however, led to a number of important objections and questions.

The central objection to a radical phenomenology has been encapsulated by Rose (1975) in a discussion of Silverman's (1970) critique of conventional organisation theory. Rose begins with the proposition that a focus on the subject's definition of role or situation 'may suppress consideration of the underlying objective features of a situation in which action occurs', (1975:243). Rose goes on to question the extent to which 'actors are sovereign in defining and acting in accordance with their definition of the situation', (1975:244).



This is both a practical problem for actors – as we saw in some of the case studies which I discussed in chapter 2 – and a general theoretical problem for phenomenological sociology, with its emphasis on the constitutive powers of the subject. On the basis of the position outlined by Husserl and Schutz, and discussed earlier in the chapter, a conventional response can be offered. This would involve the basic argument that what Silverman (1970:224) has characterised as the 'subjective logic of social situations' is the proper focus of sociological enquiry. Moreover, as Walsh (1972) has argued, phenomenological sociology would 'deny the existence of the social world independently of the social meanings that its members use to account it and, hence, constitute it', (1972:49). On this basis, conceptual schema and theoretical categories for understanding the subject and the subjectively inhabited social world must be seen as subjective constitutions in themselves. Furthermore, these could only be distinguished from 'common-sense' knowledge in the sense that they operate at a higher level of abstraction.

Clearly, the programme that Silverman (1970) and Walsh (1972) offer is problematic. It assumes a sovereign subject, able to define the world freely and act on those definitions without constraint. However, such a radical approach forces phenomenological sociology along lines that lead to untenable (and unsociological) conclusions. First, it directs it towards a methodological relativism that undermines any attempt at analysis – subjective definitions become the beginning and end of sociological knowledge. At this point, it becomes impossible to distinguish between sociological and any other social knowledge. Secondly, it assumes that those factors which the subject defines as promoting or inhibiting action are *the* significant factors implicated in that situation or relationship. In other words, factors which go unrecognised – or are in some other way opaque to the actor – play no part in the autonomous and creative constitution of the subjective world.

To follow this road to its end would lead to a view of the social, then, that is disabled both by relativism, and by an unreconstructed voluntarism attributed to the actor. One constant in Silverman's work throughout this period, however, and the way in which (1970) he has attempted to resolve the problem of over-stating the autonomy of the subject or of lapsing into voluntarism, has been to point to the way in which language acts as a social resource which sustains particular ranges of subjective definition and interpretation. Through language, he argues, subjects engage with a world which is already predefined



and interpreted.

In this sense, socialisation may be seen not simply as a complex process through which the subject comes to know how the world is, but also as a means by which the subject comes to know the possibilities for being and action. In other words, socialisation involves a set of intersubjective practices which both map the past and present, but also which project the subject into the future. In this sense, the subject is implicated in a social world which is more or less pre-interpreted – and in which a repertoire, or vocabulary of knowledges about the world are available – and reside in culture and meaning systems.<sup>4</sup>

However, the sovereign creative powers of the subject – free to define situations according to a range of more or less compelling definitions and interpretations which are derived from a social vocabulary – must also be seen as constrained and subordinated. Some definitions and interpretations of the world are more compelling than others. Any discussion about constitution, then, is also about reproduction and recognition, and since the subject is by definition reflexive, it is also about resistance and contradiction. It is important to emphasise that the subject is not the passive site of consent to socially constructed discourses and knowledges, but is also the site of their rejection or transformation.

The subject's relative autonomy – in the sense that one is neither sovereign in independently constituting the social world, nor absolutely determined by it – is in relation to 'real' structures, processes and practices. However, two points need to be made here. First, these may exist in forms which delimit the interpretive powers of the subject by way of their opacity and 'naturalness' and so the 'subjective logic of social situations' (Silverman, 1972:224) must involve elements both visible and invisible to the subject. Second, as Manicas (1987) has observed, while the social world is constituted by subjects as agents, there is always the possibility that their understanding of social situations is incorrect. In consequence, the subject needs to be the focus of critical examination.

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<sup>4</sup>See Parkin (1972), for a valuable and accessible discussion of meaning systems

Despite the possibilities for opacity and misunderstanding, it is still necessary to appeal to the interpretive resources of subjects to explore the ways in which the 'real' world is 'incarnate' (Manicas, 1987:275) in, and dependent on, their social practices. While subjects are the sites of the reproduction, contradiction and transformation of social structures, processes and practices their interpretive understandings, or subjective logics, *can* be connected with more elevated modes of *verstehen* as we shall see in the discussion which follows. Before doing so, however, I wish to point to the ways in which Bhaskar (1982) locates the relations between actors and social structures.

Society is not the unconditioned creation of human agency (voluntarism), but neither does it exist independently of it (reification). And individual action neither completely determines (individualism) nor is completely determined by (determinism) social forms. In [this conception] unintended consequences, unacknowledged conditions and tacit skills (...) limit the actor's understanding of the social world, while unacknowledged (unconscious) motivation limits one's understanding of one's self. (1982:286)

### 3.3.3. First and second level concepts of *verstehen*

Bernstein (1976:138) argues that Schutz's notion of *verstehen* needs to be clearly differentiated at three levels: as an experiential form of human knowledge; at the level of an epistemological problem; and as a method 'peculiar to the social sciences'. So far in this chapter, my discussion has revolved around the first of these; exploring the ways in which it involves the 'private' or 'interior' knowledge of the subject, and in which it forms the shared resource for intersubjective relations. As a methodological problem, *verstehen* demands careful consideration: and again, for Bernstein (1976:140) this involves an act of differentiation.

Just as we need to make a careful distinction between *verstehen* as a first-level process through which we all interpret the world, and *verstehen* as a second-level process through which the social scientist seeks to understand the first-level process, so we too can say that the purpose of second-level ideal types that the social scientist constructs is to explain the first-level ideal types that we use in everyday interpretation.



Bernstein emphasises Schutz's commitment to social *science*: and Schutz is concerned to reject any accusation that his programme is *subjective* (1971:274) in the sense that it is an intuitive and unverifiable project. But this raises questions about its scientific status – in the tension between subjective understanding and objective categorisation – given that social scientific enquiry is distinguished from 'natural' science by its attempts to objectify subjective human phenomena. (While the construction of ideal types of meaning, action, and intersubjectivity at an explanatory or theoretical level is undertaken through subjective processes.) For Bernstein, this involves the social scientist in three dimensions of activity: participation in the everyday life world and its common-sense interpretation; distinctive forms of social activity within the social scientific community; which leads to the intersubjective verification of concepts, hypotheses, descriptions and explanations through the intersubjectively constructed norms of that community.

Here, what is pre-theoretical, (ie. the typifications and ideal types sedimented into the consciousness of actors, and transmitted through intersubjective processes), is rendered open to the theoretical and critical gaze of the community of social scientists in a way that neither collapses into reified empiricism or into the sphere of the purely subjective. In this way, the outcome of theoretical or empirical work can be seen as neither relative nor arbitrary. The observation or interrogation of actors in the social world; the development of categories or typifications of phenomena associated with them; and the activation of broader theoretical schemes, are – as Schutz puts it – subject to demands for logical consistency and adequacy.

The latter [adequacy] means that each term in such a scientific model must be constructed in such a way that a human act performed in the real world by an individual actor as indicated by the typical construct would be understandable to the actor himself, as well as to his fellow men in terms of common-sense interpretation of everyday life. Compliance with the postulate of logical consistency warrants the objective validity of thought objects constructed by the social scientist; compliance with the postulate of adequacy warrants their compatibility with the constructs of the everyday world. (1962:1,63-64)

Schutz's position does not correspond to a 'pure' phenomenology, and as

Ainley (1987) and many others have pointed out, it takes significant points of departure from Husserl's programme. Schutz does insist on the vital importance of the common-sense world in which social actors are located as the starting point for sociological analysis, and my purpose in this discussion so far has been to outline the theoretical foundation for my own empirical work.

### 3.4. The interview as the source of subjective accounts

The thrust of this chapter, so far, has been to point to the way in which – as Bhaskar (1979;1982) and Silverman (1985) have asserted – a subjectivist social research method may 'deal with a reality that is already pre-interpreted by its members' (1985:42). In my discussion of Schutz's phenomenological perspective I have drawn attention to the processes through which this is undertaken (first order *verstehen*); and at the senses through which it may be understood, (second order *verstehen*).

I now wish to move on from this discussion of epistemological issues connected to the subjectivist frame of reference, and its claims to scientific authenticity, and ground them in practical aspects of the study – how nurses define and understand their relationships with patients, and how this can be understood. Operating from the perspective so far in this chapter, this study employed informal and semi-structured interviews as a means of interrogating the subjective experience and understanding held by the nurse, and the meanings and significance that they attributed to different configurations of social relations and practices.

In order for this 'private' complex of common-sense knowledges to be transformed into material open to exploration and analysis it must first be made 'publicly' available in some way. One conventional site for the production of this type of data is the interview: which is a purposive social interaction explicitly intended as a 'device (...) to reveal patterns of social knowledge', (Brenner, 1978:123). The interview is not self-evident as an interaction, and the form of analysis employed in this study – which relies on the constant comparison of nurses' accounts – demands that it be given serious attention as a problematic source of data.

### 3.4.1. The interview as a dyadic function

The semi-structured and informal mode of interviewing employed in this study has to be seen at the outset as more than a technical problem of data gathering. While it *is* the site of specific research techniques these cannot be disconnected from the social encounter in which they are operationalised. The key point which needs to be made here is that the interview itself involves a social relationship between actors, organised around and shaped through the development of a purposive and interactive discourse between subjects. As McCall and Simmons (1966) have asserted, the interview is a dyadic engagement which cannot be reduced to the single function of one participant, but which requires joint action. The respondent's account,<sup>5</sup> then, emerges in the context of interaction not simply between interviewer and respondent, but between subject and subject, and is driven by intersubjective practices in the same way as any other encounter. As a result, the meanings attributed in this discourse are jointly constituted through conversational practices which involve negotiation and legitimation of the form which the exchange takes, and of the meanings of indexical terms within it.

The interactive character of the interview, and the joint production of discourse within it means that the respondent's subjective account is not self-contained or straightforward, but needs to be seen as contextually grounded.<sup>6</sup> In this sense, the account is *dependent* on its joint production and this view demands that the interview be seen as more than a set of questions and answers, in which the interviewer creates discursive 'spaces' which are 'filled' by the respondent. In the conventional survey interview, the joint production of meaning is suppressed, as far as possible (Brenner, 1983; Mishler, 1986). However, within the quasi-conversational informal interview this provides a unique contextual dimension, and this has a cumulative effect on the production of discourse by both participants, which demands more than linguistic competence – but social co-operation as well.

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<sup>5</sup> I should emphasise that in using the term 'account' I restrict it to its 'common-sense' meaning. Rather than deploying it to meet a more sophisticated theoretical objective, I use it simply to characterise what respondents said in the course of interviews.

<sup>6</sup> I should emphasise that by this I mean the context of the interview, rather than the context which the account mediates.

Brenner (1978) locates the sources of this co-operation, (and hence the stability of the interaction), in the enactment of roles and rules within the interview. These are normally under-identified, but involve the participants' tacit attribution of particular forms of social competence and responsibility to each other. Through this tacit knowledge about what the interview *is* boundaries of discursive conduct are maintained and this leads to the production of relatively orderly discourse. This is maintained through the negotiation and legitimation of tacit understandings: participants co-operate to ensure that the interview terminates satisfactorily by behaving in ways which they normatively recognise as adequate to the resolution of the task – the eliciting and giving of information – as Weinstein and Deutschberger (1964) have pointed out. Brenner asserts that the interview remains contingent on continued tacit agreement about the role and rule boundaries of the interview, and emphasises the importance of *tasks* in ensuring that this agreement is maintained. He recognises, however, that the contingency of the interview means that it is also liable to decay into interactions which are organised around other tasks, because of the voluntary character of the respondent:

As regards the respondent, he is much freer in his role enactment than is the interviewer. At any time, he can enlarge on the definition of the situation as interview by reading the interview also as an interesting and satisfying encounter, and as a chance to express his dislikes, disappointments and ideas. Also he can read the interviewer's performance within his own relational standards as an improper fulfilment of the interaction contract on various grounds. He can doubt the propriety and sense of the questions as well as the the style of questioning. He can challenge the interviewer as a person on a variety of grounds, for example, by doubting the interviewer's competence. Finally, he can use idiosyncratic ways of enacting his task role. (1978:130)

In the informal interview participants' roles are under-identified, and the task-status of the encounter is open to doubt, precisely because it is not a simple series of questions and answers – but is an interrogative and purposive conversation in which new lines of enquiry are constantly opened up to pursuit by the researcher. This means that the discourse between them involves a continuing dimension of negotiation and legitimation throughout the duration of the interaction.

Negotiation is not confined to the propriety of questions, rules, or roles within the interview, but also extends into the sphere of meaning. This does involve issues of linguistic competence, in that although participants jointly constitute meaning through symbolic speech acts (Gumperz, 1982), questions and answers are linguistically complex. Here, participants penetrate meaning through determining that the form which discourse takes makes meaning accessible to the other; through subsidiary explanation, questions and answers. This may not involve more precise definition of terms, but instead may require their being placed 'in context'. This is achieved either through relating the term to historical features of the interview discourse – in which an indexical term like 'thing' has an established meaning within that which has already taken place – or through projecting an indexical term onto its practical use outside of the interview, in the use of the term 'relationship', for example. In this way ambiguity is resolved through the co-operative efforts of the participants to give terms concrete substance through reference to events already understood, or about to be explained.

### 3.4.2 Problematic features of the subjective account

Having established that the subjective account given by the respondent is produced through jointly constituted discourse with the interviewer, I want to turn now to the way in which such accounts contain problematic elements which must be taken into consideration before their possibilities as data can be considered.

I want to begin with the proposition that although accounts are *autobiographical* they cannot be seen as representing the experience or understandings to which they refer in any complete way. The subjective experience of the actor has no concrete independent existence as reality, and is biographically interrogated by the subject in a way which, as we have seen, involves reinterpretation and reconstitution across a temporal as well as an experiential dimension. In this sense *verstehen* is contextual not only in the way in which it is tied to a historically situated 'moment', (and to the conditions which pertained at that moment), but because it is tied to the actor's constant confrontation with new experiences and the reinterpretation of events. In consequence, its reconstitution in *retrospect* has to be seen as being filtered through the actors' engagement with those conditions which



have pertained since the moment under the subjective gaze.

The serious implication of *verstehen* as the retrospective understanding of the actor lies in the way in which the subjective account is historically dislocated from the events and contextual conditions to which it refers. Put simply, this means that biographical moments are viewed from the context of the present. It cannot be said, therefore, that the subjective account reproduces any given moment in a complete form. This is partly because of the parameters of everyday language: but beyond these is the way in which concrete and mental experience in the formation of each 'moment' cease to be available to the actor over time. Events may be recalled, but are not re-experienced in their immediacy. A study dependent on the retrospective accounts of the actor as this one is, is affected, therefore, not just by the mental mechanisms of recall involved in their production – but by the way in which their historical dislocation means that they are artificially reconstituted. This does not mean that accounts are *inauthentic*, but that they involve the prioritisation of their internal elements, and this leads to patterns of emphasis and absence that may not correspond directly to the constellation of experience and understanding which the account represents.

The reconstructed account has to be seen as partial because of this. In the processes involved in its representation, it comes to address the context to which it is delivered by mediating between the moment of production, and the moment under scrutiny, in a reassembled form. The account is adjusted in engagement with the actor's knowledge about the different social conditions in which it is produced.

At issue here are the actor's assumptions about relevance and adequacy, and the way in which these are socially defined in connection with the context in which accounts are reproduced. A simple example of this would be the variation in an account of the treatment of a pressure sore given by a staff nurse to a group of students under instruction, or to a distressed relative. Accounts are reassembled in these circumstances to meet what the staff nurse 'knows' about the interaction in which they are given. The intersubjective norms which govern such situations mean that departure from a jointly constituted and accepted definition of what is adequate and relevant involves some risk.

Of course, accounts of the subjective cannot be considered to be neutral. They

represent *interests*. In doing so, they are assembled in correspondence with power relations, goals and motives, and given purposefully with those in mind. The respondent adjusts the pattern of emphases and omissions in a form which explains actions and experiences in a legitimising way. A convenient, if imperfect, example of this is the account which I have given of this study in Chapter 4.

In pointing to the ways in which accounts are assembled to give a legitimating authority to the experience of the actor, we encounter a further problem. The outcome of intentional and purposive action is always uncertain and unpredictable. Continuing to use chapter 4 as an example, this was – and continues to be – the case. In chapter 4, however, I impose an artificial order on events that contains assumptions about how and why things worked out as they did. This post-hoc rationalisation omits a whole range of other experiences and reconstitutes what is left into an apparently unproblematic smooth progression. What I take-for-granted now is clearly only a very small part of my biography, and that part of it available to others is smaller still.

My intention in this discussion has been to point to two key features of accounts of the subjective experience of actors. That they are not neutral, but are assembled to meet the respondent's personal political interests, in which context they act as an explicit form of retrospective rationalisation of events; and that assembling an account in this way legitimates and validates it in ways that meet the requirements of particular social situations.

### 3.5. Theoretical focus: towards practice

So far, I have pointed to a particular set of problems associated with the subjective account, and with the interview as the site of its reproduction. These problematic features of the generation and content of the account must have a constraining effect on the way in which the subject's account can be seen as *data* representing social 'reality'.

The specific character of the account and of the interaction through which it is mediated – in the sense that they manifest unique human experience – is the major problem that needs to be overcome before any systematic model of analytical procedure can be presented. Given that any interaction and relationship is the outcome of a specific configuration of social practices and



processes, in what sense can the accounts mediated within them be seen as internally or externally valid?

This question has clear implications for the survey interview, as Hyman (1954); Brenner (1983); and Mishler (1986) have pointed out. The standardised survey interview relies on the direct and unproblematic compatibility of questions and answers across interview boundaries: that is, that interview *a* is not contextually distinctive from interview *b*, and that answers are directly comparable between them. In the informal interview contextual distinctiveness is not suppressed, but is the inevitable outcome of an approach which involves a variable interview schedule, and changing ideas within the interview about the meaning and significance of elements in the subject's response. Hence, the account given by respondent *a* is never directly comparable or compatible with that given by respondent *b*.

As we have seen, accounts are contextually grounded, and are dependent on the elaborate joint construction of discourse within the interview, and so the form in which the account is reproduced in the interview is 'contrived' (Silverman, 1985). It is reassembled, or reconstituted, in relation to the specific dynamics of the the interview, and as such has no simple correspondence to the 'real' world. Such a position obviously raises questions about the way in which *any* subjective account given in an interview can be reasonably held to be an adequate report on social 'reality': but if the account is to be regarded as more than an interesting set of linguistic practices, or the effect of a taxonomy of roles and rules within the interview as a social interaction, this problem needs to be resolved in a way which allows the development of a rigorous analytical position for the definition of data, and such a resolution must also avoid a collapse into phenomenological relativism.

The validation of the respondent's account is established through a redefinition of its status. It needs to be emphasised that this is not to question its veracity: but instead is intended to allow for the ways in which *verstehen* is fluid. Interpretive understanding is accomplished in constant transformation through the effect of subjective and intersubjective processes. As we have seen in the previous discussion, the thrust of this chapter has been to disable the common-sense notion that subjective accounts correspond directly to the subject's experiences and understandings

Silverman (1985) suggests that accounts, as interview data, need not be seen

as true or false reports, but as 'displays of perspective, or moral forms', (1985:170). These are 'cultural particulars (...) representing variable social practices'. Silverman characterises his position as realist, arguing that as 'displays of reality' (1985:173) accounts are 'reciprocally related to social practice'. In this sense, the particulars of an account represent condensations and elaborations of "insiders" knowledge' of a social reality, and have a correspondence with the way in which the respondent understands and acts within, (what they understand to be), the social structures and processes which form the framework through which different activities and aspirations are ordered and shaped.

Silverman's position offers a compromise in which subjective meanings are not dislocated from the subject's understanding and experience of powerful structural relations. It also offers a useful constraint on what Glassner (1980:45) has described as 'simple subjectivism' in which the subjective account is accorded the status of a direct and unproblematic correspondence with the experience which it mediates and represents.

By redefining the account as a set of particulars, permeated with the legitimative authority of the subject's common-sense world-view, and representing the subject's understanding of action taking place within an organising and constraining structure - its status as data is transformed. As a perspective on experience, these particulars represent a subjective set of categories not simply about action, but about the common-sense cosmology in which the subject locates action. In this way an account transmits essential features of *verstehen* into the present: and these take the form of *conceptual regularities*, discrete categories of discourse which relate to cultural particulars of experience and understanding and mediate them in an emergent form.

The realist redefinition of the account construes it as a discursive entity which occupies an intermediate position: between the 'facts about the world' of a positivist perspective, and the 'conversational practices' of an ethnomethodological position. By defining the account as a set of revealing categories which relate to the subjectively transformed understanding of the 'realities' of experience of a social world where social practices and processes have concrete effects, the uniqueness of accounts and interaction becomes the terrain on which common features and regularities are sought. These common features, both within the 'history' that accounts represent, and across interview

boundaries, become the objects of analytical procedure. However, because experiences are uniquely constituted and understood, it is relations of similarity, rather than directly comparable categories which validate accounts.

In this chapter I have emphasised the paramount reality, or facticity, of the subject's experiential engagement with the every-day *lebenswelt*; and the emergent and altered form in which it is represented and reproduced in the interactive discourse of the interview. In doing so, my objective has been to direct attention at three key problems for empirical research: the constitution of the common-sense world; how it may be interrogated; and the limits that must be placed on claims about the outcome of that interrogation. It is immediately apparent, however, that the position that I have outlined involves compromises and tensions in relation to the 'phenomenological' enterprise – both within it, in terms of its relation to the programme outlined by Schutz, or by Berger<sup>7</sup> – and beyond it, in terms of the 'realist' position set out by Bhaskar, Sayer, and Silverman.

The location of the theoretical basis of this study in a tension between 'phenomenological' and 'realist' sociology has involved stepping back from the conventional, interactionist basis of the research method described in the next chapter. Such a position is by no means novel, as Silverman (1985) has shown. Its strength lies in the way in which it opens up the most problematic element of a subjectivist research practice, ie. the relation between subjects and structures. Conventionally, 'micro-sociological' perspectives have been concerned with the relationship between subjects as these are expressed in symbolic constructions of interaction, or in linguistic praxis<sup>8</sup>, and have neglected the forces which are exerted by structures and practices which are opaque, as Yearley (1988) puts it, to the subject.

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<sup>7</sup> Neither Schutz nor Berger offers a detailed programme for research practice; indeed, both seem to have deliberately distanced themselves from such a task, as Ainley (1987) has observed.

<sup>8</sup> The work of Eliot Mishler (1986), for example.

## CHAPTER 4

### RESEARCH METHOD: PRACTICE

#### 4.1. Introduction

In the preceding chapter I have outlined in detail some of the theoretical issues that underpin the qualitative or intensive research perspective which informs this study, and the use of unstructured or semi-structured interviews as a means of collecting data. This chapter is concerned with the ways in which these theoretical concerns were put into practice, and has two main objectives. First, to outline the practical problems, choices and negotiations involved in undertaking the study in the field; and second, to describe the procedures and instruments through which data was collected, collated and analysed.

#### 4.2. Contending approaches to the fieldwork

As the general focus of this study was being decided, I was also making decisions about how the study could best be conducted in practice. There were four possible ways in which this could have been done. Participant observation, (in which I would have worked in some capacity on the ward or wards); non-participant observation, (in which I would have taken some vantage point to examine the character of interactions – either in person, or like Macleod Clark, 1982, using remote surveillance); a combination of observation and interviews; or by interview alone. I adopted the last of these approaches.

Observation seemed to me to present two major problems. First of these, and perhaps the less important, was the possible effect of my presence on patients' morale if the focus of my study became known to them. More serious was the potential effect of an observer on the character of interactions between nurses and patients. If 'informal' comfort and counsel was a feature of interactions between some nurses and patients I was anxious not to inhibit it. There was an important ethical dimension to this: the formulation and enactment of these

interactions may demand privacy as a condition of their existence.<sup>1</sup> Given their potential significance to the patient – as a moment when fears and anxieties are confronted and expressed – I felt that it would be wrong to intrude, and through my presence inhibit either participant. In the light of some of the data presented in chapter 7, this is not a decision that I regret.

There were also practical considerations that needed to be taken into account. Participant observation raised the question of precisely how a researcher without a nursing background may participate in the nursing care of patients; one way to do this would have been to work on a ward or wards as some kind of ancillary worker – a ward cleaner or housekeeper, perhaps – but my experience of working in this capacity suggested that I would find it difficult to keep the encounters in which I was interested in focus, if I saw them at all. Any kind of observation also raises questions about its general effects on the social arrangements on which the study is focused, as Rose (1975) has pointed out. In chapter 2, I have suggested that the results of Macleod Clark's (1982) study may have been profoundly affected by her use of remote observation technologies.

While these practical problems were not insurmountable, my developing interest in the range of nurses' biographical experience could not have been accommodated by observation alone. This interest led, as I discuss later in this chapter, to my drawing respondents from a wide range of wards, and this in turn raised questions about which wards I would observe, and which nurses. Concentrating the fieldwork through interviews liberated the study from these ethical and practical problems.

#### **4.3. Research site and sample of nurses**

The identification of informal, semi-structured interviews as the appropriate instrument for collecting data in this study opened up a range of problems regarding the site and context of the research. In the following discussions I outline the logic underlying decisions about the practical research strategy and describe the negotiations involved in obtaining access to the site and to a

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<sup>1</sup>As Weir (1977) points out.



sample of nurses.

#### 4.3.1. Selection criteria: the site

In the UK nearly 70% of deaths take place in hospitals and other institutions (Field, 1989), but these are unequally distributed across clinical specialisms and types of establishment, ranging from less than 1% in maternity units (Oakley, 1984), to approaching 100% in hospices and some geriatric units. This uneven distribution reflects the shifting demography of death. Since the 1930s there has been a radical decline in mortality in early and mid-life. In the same period, largely as a result of improved health care the number of elderly members of the population has increased, with the multiple health problems associated with that demographic group, (Turner, 1987). The impact of AIDS on this distribution of mortality across the population remains unclear. The experience of death and dying is increasingly one which is contained within institutions and, like childbirth, excluded from the home.<sup>2</sup>

At the inception of this study I decided that it would focus on the acute service of a general hospital – rather than on a hospice – and that within the hospital it would exclude nurses working in clinical oncology and radiotherapy departments.

A general hospital was chosen over a hospice, and oncology and radiotherapy nurses excluded for a number of reasons. The highly specific clinical objectives of hospices, and the ideology of caring articulated by those connected with them (see for example, Saunders *et al*, 1978;1981) leads to a specific approach both to the patient, and also to those who work with them. Initially at least, the hospice movement promised nurses within it a much higher degree of social and emotional support, and much higher staff-patient ratios than the conventional hospital. While some recent work has cast doubts on these claims (Gray, 1977; James, 1986; Field, 1989;) <sup>3</sup> nurses who work in hospices do so in

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<sup>2</sup>An important consequence of this is that very few nurses have encountered dying and death prior to their training.

<sup>3</sup>Therese Mazer (personal communication) has pointed to the nature of the patient population of hospices as a source of stress: noting the historical shift from acute terminal illness, requiring relatively short term palliative care – notably pain control, to chronic terminal illness – demanding a greater duration and more labour intensive form of nursing care.



the knowledge that they will encounter terminal illness, dying, and death – and will be exposed to the stresses and anxieties consequent on this – to a far greater degree than their peers in other specialities or in general medical or surgical nursing. A similar consideration – though perhaps of a different magnitude – applies to nurses working in oncology and radiotherapy departments of general hospitals. In general surgical and medical nursing, and in some specialties, terminal illness, and mortality are relatively less frequent and are problematic in quite different ways.<sup>4</sup>

Once the decision had been made to focus on the acute service of a general hospital, the selection of a suitable site was relatively simple. I had met nurses working in a number of hospitals during the course of the exploratory interviews discussed elsewhere in this chapter, along with a number of hospital chaplaincy staff. There were several possible sites for the study, and the final location – given the pseudonym 'Metropolitan General' for the purposes of this study – was selected after an informal visit to the site, checking to ensure that there was no similar research being undertaken there, and a final discussion with the supervisors of the study.

#### **4.3.2. Negotiating access**

In many respects obtaining access to the hospital was the easiest part of the exercise. I wrote initially to the appropriate officer of the Regional Health Board responsible for Metropolitan, who arranged for me to meet with its Director of Nursing Services (DNS), to whom I presented a brief synopsis of my proposal for the study. We met in September 1988, and at this meeting permission to undertake the study at the hospital was readily given. The DNS agreed that I would be supplied with a list of nurses who met the selection criteria for inclusion in the study, and that the interviews could take place between January and May 1989. It was also agreed that interviews would take place during nurses' normal shifts and that cover would be provided during their absence from the ward, and a room was also set aside for conducting interviews.

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<sup>4</sup>As we have seen in some of the research discussed in Chapter 2.

However, it was not possible to commence interviews until May 1989. This substantial delay was a consequence of the nurses' pay dispute of autumn 1988, and the subsequent regrading exercise. This led to what one respondent in the study later characterised as 'a collapse in nurses' morale' and 'administrative chaos'. Although nurses at Metropolitan did not take industrial action, the regrading exercise generated much resentment and frustration about the way in which it was carried out, and at the grades finally assigned to individual nurses. At the time of interview several of the respondents in this study intended to appeal against their grade to the the Secretary of State.

At the same time, the administrative officer involved with making the arrangements for my access to hospital staff left Metropolitan – and it was not until late March 1989 that I met her replacement and the nurse managers responsible for specific units.<sup>5</sup> In effect, this meeting was about renegotiating access, but again this was established relatively unproblematically – and individual nurse managers expressed enthusiasm about the topic of the study. At the end of April 1989 I received the list of nurses who met the selection criteria for the study.

#### 4.3.3. A strategy for interviews

Concurrent with decisions about the location of the study, I was also considering the way in which nurses would be selected as appropriate respondents. The important issue here was how the study would focus on their work and how this would be placed in context. A review of the existing research brought into the foreground four main approaches – or strategies – to the study.

- Patient Case Histories: in this approach the research context is located directly on the patient. Nurses associated with a specific patient are interviewed throughout the duration of his or her hospitalisation. An example of this approach may be found in Strauss's (1968) study of the *status passage* and *dying trajectory* within the hospital career of a terminally ill

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<sup>5</sup>Formerly known as Nursing Officers.

cancer patient.<sup>6</sup>

- Single Ward Studies: here nurses working on a single ward are interviewed in detail about their experience of the social relations and practices within that context. Field (1984), among others, has produced work which uses the ward as its research context, and this has been discussed in detail in Chapter 2.
- Comparative Ward Studies: in this approach the research context is located in the points of similarity and dissonance between two or more discrete workplaces. May and Kelly (1982), for example, have explored on a comparative basis the social organisation of legitimisation practices between two psychiatric wards.
- Status Sample Studies: here, nurses working at a specific grade or level of experience are interviewed about their work in a variety of contexts. Quint (1967); Simpson *et al* (1979); and Melia (1981) have used this approach in studies of student nurses.

I adopted the last approach in this study for a number of reasons. First, I wanted to obtain data about the definition and constitution of relationships with patients from nurses working in a variety of wards and clinical specialties. Here, I was interested in their common definitions and experiences. Beyond the context of their present activities, however, I wanted to explore how the ways in which they defined and understood their relationships with patients and acted within them might have changed over time.

My interest in these two dimensions or *axes* of experience – the immediate context of the respondents nursing work, and how their ideas about nurse-patient relationships were shaped by their work history – meant that a status sample offered a number of practical advantages over more specific studies of individual patients or wards.

I set the marker which defined this sample at 2+ years post-qualification

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<sup>6</sup>Strauss *et al* characterise the dying trajectory as the 'perceived course of [the patient's] dying' (1968:12).

experience.<sup>7</sup> Of course, any temporal definition of experience is to some extent arbitrary, since it takes no account of the intensity or type of work undertaken during the period specified. A nurse who has spent three years working in oncology before moving onto a general surgical ward might be expected to have a radically different perspective on nursing care from one who had spent the same period working in orthopaedics.<sup>8</sup> I saw this as an advantage, however, in that it opened up the question of what might be common between those different experiences.

From the inception of the study I focused on staff nurses. The staff nurse has a range of administrative, managerial and educational duties over and above direct patient care, and some recent work has suggested that direct patient care might take up only around 45% of the staff nurse's time on the ward (Waite *et al*, 1989). Although student nurses and auxiliaries spend more time with patients, (and charge nurses much less), it is the staff nurse who is primarily responsible for organising patient care, and I was interested in the ways in which this might involve conflict between different *types* of nursing work and the impact that this might have on the nurse-patient relationship.

In Chapter 2 I suggested that the management of the ward is an important factor in the ways in which relations between nurses and patients are socially organised, and for this reason I was much less interested in charge nurses – who have a much more defined managerial role than staff nurses – although staff nurses will regularly 'act up' in the charge nurse's absence. My main interest here was in the ways in which nurses saw the charge nurse's ideas about nurse-patient relationships as constraining or promoting their own activities.

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<sup>7</sup>After discussion with the Director of Nursing Services. I had originally intended to set this marker at 4+ years, but at the time at which access to the hospital was being arranged there were simply not enough staff nurses with this length of post qualification experience working at Metropolitan.

<sup>8</sup>In fact, only one nurse had spent more than two years on any one ward since qualifying. Turnover of nursing staff at Metropolitan was rapid, and once I realised this I asked respondents how long nurses normally stayed on the ward on which they worked. Answers to this were obviously approximate, but between one year and eighteen months was a common response. (Except in the neurosurgical ward, where not only did staff work for a relatively longer period of time but there was a waiting list of applicants for those posts that did arise.) See Pape (1964) for a discussion of the phenomenon of 'touristry'.

#### 4.3.4. Sample Selection and obtaining respondents

Once the parameters of the status sample had been defined, nurse managers were asked to identify those members of their staff who met the following criteria:

1. That they were staff nurses, and had not worked at the rank of charge nurse on other wards in Metropolitan hospital (or at other hospitals).
2. That they should have a minimum of two years post-registration experience as Registered General Nurses.
3. That they should be currently working on acute medical or surgical wards where they regularly encountered adult patients who had a terminal diagnosis, or who were dying.

Once these potential respondents were identified the Assistant Director of Nursing Services forwarded their names to me, it having already been agreed that I would initially approach them by letter. If they agreed to take part in the study, it was intended that an appointment for the interview would be made through the nurse manager.

At Metropolitan, 39 nurses - working on general medical and surgical, neurological, gastro-intestinal, and orthopaedic wards - met the selection criteria at April 1989. Between April and June I wrote to each of these nurses, inviting them to take part in the study. A copy of the brief description of the project that I sent with it is shown at Appendix 2. Of these nurses:

- 15 agreed to take part in the study and were interviewed.
- 1 agreed to take part in the study but rotated onto night duty before an interview could take place.
- 1 withdrew prior to being interviewed, for personal reasons.
- 1 agreed to take part in the study, but did not attend the interview. When this was rescheduled, the nurse still did not attend, and subsequently withdrew.
- 3 left the hospital during the period in which interviews were conducted.

- 18 either refused to take part in the study, or failed to respond to the invitation.

Of the 15 nurses interviewed, 12 were senior nurses who regularly took charge of the ward. All were aged between 24 and 30; seven had degrees in Nursing; two of the remainder were undertaking further study part-time; and only five had not worked at Metropolitan at some time during their training. Four of the graduate respondents intended to leave the hospital in the foreseeable future, either to work in the community, or to leave the profession altogether. Of the non-graduates, only one intended to leave the hospital, and this was to obtain promotion elsewhere. Three of the respondents were male.

Although it had originally been intended that appointments with respondents would be made through the nurse manager responsible for each unit - who would then ensure that respondents' absences from the ward could be covered by other staff - this system quickly broke down, and I contacted respondents directly. This worked more smoothly, as a considerable period of time often elapsed between the nurse receiving my letter, and agreeing to take part in the study. Normally this period was about three weeks, but the maximum was eight.

#### **4.3.5. Factors affecting response**

In my initial discussions with the nursing administrators at Metropolitan, a good deal of time had been devoted to ensuring that the study would not create problems in terms of its resource implications for the wards from which respondents were drawn. In fact, although careful arrangements were made - interviews were timetabled for between 2 and 4 in the afternoon, in which two shifts are working concurrently on a ward<sup>9</sup> - to ensure that the study did not cause problems for wards, and that where this could not be managed the interview was rescheduled, there were problems. The following account brings these out:

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<sup>9</sup>The early shift at Metropolitan works from 7am until 3.30pm, and the late shift, or 'back shift', runs from 1.30pm until 9.30pm.



Nurse:

You know, we all got our letters together and the responses were amazing - 'I don't know about these things' and then there was the time, 'I couldn't leave the ward' - and the ward *will* run. And then it's research of course, the University of Edinburgh,<sup>10</sup> so I didn't know what I was coming to, the whole level of questions, I didn't know if I could cope.

I knew the ward would be like that. Nurses are accountable for the physical workload of the ward, and if the ward is busy then - you know - but I was there when they opened them and I knew exactly what the comments would be. I did a study in [School of Nursing] and I got the same answers.

There are two significant features of this account. First, is the *known* effect of leaving colleagues to cover a 'busy' ward and the question 'will they cope?' Second, is the potential respondents perception of the *unknown* within the interview and the question, 'will I cope?' Clearly, these two questions are intimately linked to each other, but I have insufficient data to do more than speculate on the nature of that connection. What did become very rapidly apparent during the course of the fieldwork was that a successful interview with one nurse - followed by their giving a favourable report to colleagues on the ward - would lead to further positive responses.

The attitude of Nurse Managers was also important. Where the Nurse Manager took a 'hands off' approach to the study, it was apparent that fewer respondents came forward, and more of those that did then withdrew. On one unit, however, a popular Nurse Manager took a quite different approach, encouraging nurses to take part and ensuring that cover was available for their absence from the ward well in advance of the interview date. 8 out of 15 respondents came from this unit, which held 17 out of 39 potential respondents.

While the reasons for non-response remain difficult to ascertain, it was possible to identify two distinctive groups among those who did respond and

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<sup>10</sup> Departmental letterhead notepaper was used for the letters sent to potential respondents, in line with faculty policy.

attend the interview.

The first of these saw the interview as an opportunity to 'let off steam' and to articulate specific or general complaints about aspects of their work and its organisation. Their accounts are dominated by what Turner (1987:152) has characterised as a 'vocabulary of complaint' focused on workload, organisation, interpersonal relations between nurses, and between medical staff and nurses. Several of these respondents were explicit about their perception of my role as researcher - which they saw as a channel of communication for these grievances between themselves and senior members of the nursing administration or medical staff, through which their recommendations and demands could enter the public arena anonymously. Significantly, many of these were made in the form of 'off the record' statements for which the tape recorder was switched off.

The second group of respondents emphasised their professional status and were explicit about contributing to research as a way of improving both the image and the practice of nursing. One respondent saying, about colleagues who had decided not to take part in the study, 'they don't realise that if they don't actually contribute to research, then nothing's going to change'. Several of these nurses had a developing interest in terminal care as an area in which they were interested in specialising, and on a number of occasions respondents made connections between this interest and the emerging crisis over HIV and AIDS, which again was seen as a potential area of specialisation.

#### **4.3.6. The Interviews**

Interviews were held in one of the medical staff offices in the general medical and surgical unit, and their format remained largely unchanged throughout the duration of the fieldwork. In this type of interview, which is loosely structured and very informal, the researcher has only a very short time to gain the confidence of the respondent, and to establish his or her self as a sympathetic and trustworthy co-respondent. On arrival nurses were often unsure of what was going to happen, and as a consequence were nervous or ill at ease. My interview practice tried to cater for this, by making the first few moments of the meeting as easy as possible for the nurse.

After initial pleasantries in which I introduced myself again, I would give the

nurse a brief explanation of the format of the interview, the following is a fairly typical example of this:

CRM: OK, I just want to tell you a few things before we start. First of all, I'm not a nurse, so there may be times when I have to ask you to explain what technical terms mean, or how something works. The other thing is the tape recorder - now - are you happy about that?

Nurse: Yes.

CRM: That's great. If there's anything you want to say, and don't want recorded, or if you get uncomfortable with the tape-recorder, just tell me and I'll switch it off. Another thing is that everything you tell me is confidential - so when I in some of the questions say that a nurse has told me something, then it's not any of your colleagues here, but nurses that I spoke to when I did the pilot for the study. Is everything OK?

Nurse: Yes, that's fine.

CRM: Good, good, now - how long have you been on the ward?

In fact, although some nurses made 'off the record' statements for which the tape recorder was briefly switched off, nobody objected to the interview being recorded. I used a Sony TCM2 pocket cassette recorder, and high resolution tapes.

Initially, at least, I was overly concerned about the success of interviews as general social interactions, rather than as interviews. This meant that for the first two or three interviews I intervened too much, and often at inappropriate points. In concentrating on keeping the respondent happy, I often missed or let go important pieces of data. As the interviews progressed, however, I said much less, and listened more carefully - following up points as they arose rather than noting them down and coming back to them at a later stage of the interview. I also became much more confident about using the interview schedule as it was intended to be used, as a guide rather than as a rigid instrument. One result of this was that the interviews themselves, which ranged between one and a half and three hours, produced much fuller accounts made

by the respondent, rather than short question and answer pairs. The very first interview contained 350 'turns' of speech, but by the fifth this had settled down to about 100.

Terminating interviews was much less problematic. In most cases, by the end of the encounter I had established a rapport with my respondent, and once the interview schedule had been completed, we continued to chat for a few moments. Respondents often wished to know about the project in more detail, how what they had told me would be used, and what the objectives of the study were.

#### **4.4. Collating and analysing data: constant comparison**

The model of fieldwork and analysis that I employed in this study is derived from the methodological theory and practice developed and elaborated by Glaser and Strauss *et al* (1964; 1967; 1973; 1978). However, the substantive differences between the theoretical strategy that underpins their work, which is symbolic interactionist in perspective, and the perspective of this study, means that although I owe them a great debt – there are also important separations and points of departure.

In the 'constant comparative' method, data collection, collation and analysis are concurrent, and Glaser *et al* make no formal distinction between them as parts of the research act. The researcher enters the field with a general problem in mind, and with a theoretical perspective that informs that problem, but Glaser and Strauss argue that the objective of fieldwork need not be to test specific hypotheses – but rather that these emerge out of qualitative or extensive research, and they assert that research may be constructed around a much more open or fluid framework. Moreover, Glaser and Strauss emphasise that all research activity in the field is more or less analytical. At the moment that it is gathered data is being defined as in some way significant, and patterns or classes of discourse or activity are being focused on as of interest. As the research progresses, this definition of what is significant becomes more deliberate, and choices about the direction of research become more informed. It is important to note, however, that an open or fluid framework for research practice does not mean that it is a disordered or unstructured set of operations. In fact there were a number of relatively orderly and discrete stages in the collection and collation of data for this study.

## Preparation

- A general research problem was identified and defined.
- A review of existing research was undertaken, in conjunction with a series of exploratory interviews.
- And finally, an initial interview schedule was designed.

## Fieldwork

- Using the initial interview schedule, a batch of five interviews was undertaken.
- Interviews were transcribed, and types of data and significant features within them were identified.
- Interview transcripts were compared, and types of data and significant features common to a number of transcripts identified and recorded.
- The interview schedule was rewritten to focus more clearly on emerging common categories of data, and to incorporate formally topics voluntarily introduced by respondents.
- This process was then repeated with a second and third batch of interviews.

## Post-fieldwork

- Interview transcripts were edited and transferred onto a computer, using a text editor program.
- Interview transcripts were coded against general categories of data. Transcribed data was collated using the the text editor into files representing these broad categories.
- Data within these broad categories was recoded, and more tightly defined sub-categories were identified. Data was then collated again, into files representing these sub-categories.

#### 4.4.1. Formal and informal hypotheses

Glaser and Strauss, *et al* have characterised this fluid basis for research as theoretically sensitive: here, the research question is framed and treated in a relatively open way, and is concurrent with a survey, or exploration, of a set of general problems. They argue that qualitative research involves working through, in an informal way, many different hypotheses. This involves a shift away from testing prescheduled hypotheses derived from large scale theoretical schemes, through an investigation of the relationships between variables. Instead, they argue that in qualitative research formal hypotheses need to arise out of the process of interpreting and analysing data. In their programme for research data collection, collation and interpretation, are concurrent and in constant engagement with each other. In the *process* of data collection the researcher locates emerging classes and categories of what Silverman (1985) has called 'cultural particulars' and as these become visible is able to subject them to increasingly deliberate and focused attention. It is at this stage that semi-formal and formal hypotheses begin to emerge.

This combination of practical and theoretical activity within the practice of research, focusing as it does upon an emerging propositional set, is rooted in the informed choices of the researcher about the collection of data that refers to specific aspects of the social arena. This set of choices, and the propositions consequent upon them, forms the daily test of a variety of hypotheses. However, it needs to be emphasised that these emergent propositions are not artificially induced, but relate intimately to the way in which respondents' discourse contains classes and categories of particulars which refer to the 'ideal types' through which *verstehen* is organised.

Highly distinctive in this strategy is the way in which 'mechanical' procedures of data collection are explicitly rejected: uniform and standardised research practices derived from rigid hypotheses are identified as inappropriate for the essentially exploratory and developmental qualitative study. The positive benefit of this lies in the way in which the inductive project – freed from the constraints of prescheduled hypotheses and analytical categorisation – is able to engage with the way in which respondents' discourses are ordered around the specific objects of their social world.



#### 4.4.2. Exploratory interviews

As part of the development of the study, a series of seven exploratory interviews were undertaken with nurses working in hospitals other than Metropolitan. These were not intended to act as a formal pilot study, and no single interview schedule was employed. Respondents in this series were obtained through personal contacts made through colleagues in the Department of Nursing Studies. Although various agendas were used, a number of common features emerged, and these led to my rethinking the focus of the project quite substantially. However, it needs to be emphasised that these were exploratory interviews with a heterogeneous group of respondents, (two of whom had recently left the profession), and that they were not intended to provide definitive material for analysis. All of the respondents found the nurse-patient relationship difficult to define as an abstract concept, but grounding its discussion in specific cases raised a number of interesting issues.

However, on one very important level, the exploratory series failed. None of the respondents was able to recall or describe an instance where they felt that they had 'befriended' a patient – and this raised questions about the form of relationship at which the study was directed and the ways in which this kind of relationship might be constructed. This led to my initial focus on the distinction between public and private, and formal and informal relationships, being extensively modified.

#### 4.4.3. The main study: interview schedule

The schedule used for the interviews in the main study, was divided into discrete groups of questions which related to different topics. The schedule itself is shown at appendix 2.

- |         |  |
|---------|--|
| Q1-13:  | were intended to settle the respondent in to the interview. These questions were largely redundant, and were omitted if the respondent was 'at ease' with the interview.   |
| Q14-22: | these questions were aimed at exploring the information available to nurse and patient about terminal prognoses. The objective here was to establish the <i>awareness context</i> in which encounters with patients were undertaken, and the |

forms of response that arose from this.

- Q23-32: were intended to explore the forms of support that the nurse provided patients confronting terminal disease, and the problems which nurses encountered in doing so.
- Q33-38: this group of questions was aimed at the distinction between 'public' and 'private' in nursing work, and the ways in which this distinction might have an impact on the nature of 'relationships' and 'involvements'.
- Q39-41: were directed at the way in which these problems might be resolved or intensified through the collective activities of the nurses working on the respondent's ward.

The schedule was not intended to act as a rigid interrogative instrument. Instead, it was designed as an informal guide to a developing conversation. When respondents introduced a new topic, or gave a detailed and interesting account in relation to an existing one, this was followed up using *ad hoc* probes. In this sense, the schedule was intended to initiate discussion about particular topics.

Similarly, it was not intended that the interview schedule would remain unchanged throughout the duration of the fieldwork. As topics emerged from the group of respondents these were incorporated into the schedule - to this end, interviews were undertaken in batches of four or five - and the schedule was regularly re-evaluated, and new topics or categories of response formed the basis of new items on the agenda. For example, in the first batch of five interviews, I noticed that nurses referred to patients' relatives when they were discussing the procedures through which patients might be made aware of their prognosis. This was incorporated into the interview schedule and produced data about the ways in which nurses used information from relatives, and also interpreted for them the information that they were given by medical staff.

Although the schedule was intended as an informal guide, it was constructed in the form of a much more ordered questionnaire. There were two reasons for this. First, there were specific issues that I wished to address within each interview and these involved presenting respondents with pieces of information

in a logical order. Second, a more formal questionnaire format can be of immense value in getting an informal discussion started – especially if the respondent is ill at ease or uncertain about the format of the interview. In this way interviews could begin in an ordered and structured way, providing a framework in which the respondent could gain confidence, and would then gradually develop into much less structured encounters. This type of agenda was also valuable on those occasions when I was confronted with a reticent or laconic respondent.

#### **4.4.4. Transcription and preparation of data**

Transcription took place as soon as possible after the interview, so that interviews could be compared with each other as the study progressed – and the emergence of common features between interviews, (as well as significant features within them), could be identified and pursued in future interviews.

The first stage of data preparation involved the production of an accurate verbatim record of the interview. This was made in longhand directly from the transcription machine, and once this transcript had been produced it was checked back against the tape, and corrections were made if necessary. Each respondent was assigned an identification number, and each turn within a transcript was also numbered. At this stage, significant features within nurses accounts were identified and recorded, in the form of very general categories that could be placed on the interview schedule as the fieldwork progressed.

As interview transcripts accumulated, these were compared with each other, and significant common features between them were also identified. Constant comparative analysis demands an organised system of collation and management of transcripts. Until quite recently, this would have been undertaken using index cards, but this can now be done using a relatively simple word processor.

Verbatim transcripts, therefore, were edited and typed up onto the University mainframe computer, and editing formed the second stage of 'formal' analysis. At this juncture, conversational 'white noise' and irrelevant material were discarded, creating a more compact and comprehensible transcript, but without losing or altering the sense of the nurse's account. An example of this is given below:

- 157CRM Yeh. So where|where you have () a patient who is coming to terms perhaps with the fact that they've got a serious illness that|that is quite possibly going to kill them, how do you u::m what kind of personal difference do you think that you can make in those circumstances>
- 158Nurse Taking time with them. I think trying to ensure that they are cared for generally by the same person, as far as that's possible working three shifts and 24 hours 7 days a week.
- To really let them get to know one or two nurses, it's easier to talk to the one that you know. A::h taking time *over*doing physical care. Often sitting a patient down and saying 'lets talk then' can be *more* frightening that anything else <talk that comes along with doing something and leads out from there/
- 159CRM yeh
- 160Nurse the patient asks one thing because you're doing whatever and that leads on, and you gradually draw the patient out that way. But knowing that you don't have to say well 'sorry I can't talk now' there are others who can do the rest of the work - and just taking time - letting the patient really decide. But picking up clues.
- 161CRM What kinds of clues?
- 162Nurse When they ask that *one* question trying just|getting them, trying to help the patient not just ignoring|getting that 'haven't got time now' you're| say it doesn't happen very often in our place. But it's hard to always think. We've got one lady who's >very quiet and she's very uptight, very anxious, but she wasn't feeling very well. And just spotting that anxiety and taking the time to sit with her/<sup>11</sup>

When edited, this becomes:

- 157CRM: So where you have a patient who is coming to terms, perhaps, with the fact that they've got a

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<sup>11</sup> The notation which I used to indicate the form which speech took was modified from Sharrock and Anderson(1986:77-79). It was used only for the first five transcripts.

serious illness that is quite possibly going to kill them, what kind of personal difference do you think that you can make in those circumstances?

158Nurse:

Taking time with them. I think trying to ensure that they are cared for, generally, by the same person, as far as that's possible working three shifts and 24 hours 7 days a week.

To really let them get to know one or two nurses, it's easier to talk to the one that you know, taking time over doing physical care. Often sitting a patient down and saying 'lets talk then' can be *more* frightening than anything else - talk that comes along with doing something and leads out from there - the patient asks one thing because you're doing whatever and that leads on, and you gradually draw the patient out that way. But knowing that you don't have to say well 'sorry I can't talk now' there are others who can do the rest of the work - and just taking time - letting the patient really decide. But picking up clues.

161CRM:

What kinds of clues?

162Nurse:

When they ask that *one* question, just trying to help the patient - not just ignoring it - or getting that 'haven't got time now' - it doesn't happen very often in our place. But it's hard to always think. We've got one lady who's very quiet and she's very uptight, very anxious, but she wasn't feeling very well. And just spotting that anxiety and taking the time to sit with her.<sup>12</sup>

Once transcripts had been typed using the computer system in edited form they could be manipulated easily using a standard text editor program.<sup>13</sup> Each transcript was held in a separate text file, and this could be copied or manipulated without difficulty. The major advantage of using a simple text manipulation and retrieval package in the management of qualitative data is that it avoids much of the time consuming clerical work previously associated with its collation and analysis. Text can be copied or manipulated through simple procedures, and blocks of text or individual words can be located and

<sup>12</sup>Brackets indicate that the respondent's words are unclear or inaudible on the tape.

<sup>13</sup>In this case EUCS SEDIT. This is a relatively simple system to operate, and runs on the University Mainframe Computer. It is now obsolete.

marked without difficulty, and then moved to other files. Similarly, items of text can be searched or compared on-line. A set of markers for this purpose had already been built into the transcripts in the form of 'turn' numbers, to which I have already referred. Item numbers from the interview schedule were also built into the transcript.

#### 4.4.5. Collating and analysing data

As I have already emphasised, the specific 'moment' in the model of qualitative research set out by Glaser and Strauss *et al* where data collection ends and formal analysis begins, is somewhat indistinct. Analytical decisions and conclusions were made continually throughout the research. However, once interviews had been completed, transcribed and typed onto the computer system, analysis did move into a more formal mode. The objective of any analytical procedure is to make sense of the mass of data that has been collected, and to make this amenable to interpretation and explanation. The following procedures were used in this study:

- General categories of data identified during the fieldwork were checked against transcripts to ensure that they were common across interview boundaries. These general categories were then assigned primary code numbers from 1 to 10. (An example of one of these categories is 'knowing' the patient, which was given the code number 6).
- General categories were subdivided into more tightly defined and specific sub-categories, and these were assigned secondary code numbers from *n*.1 to .10. (Examples of these are: 'forming a relationship' 6.2; 'picking it up in the first few days' 6.7; and, 'not knowing some of them' 6.9).
- A *pro-forma* was drawn up for each general category. This was divided up into columns representing individual transcripts, and rows representing sub-categories. Using the 'turn' number of items of data, it would then be possible to see how items of data relating to these sub-categories were distributed within individual transcripts, and also across the whole sample.
- Following Field (1989) every 'self-contained meaningful statement' within each transcript was then coded to as many categories and sub-categories as possible, and the *pro-forma*



was used to record this.<sup>14</sup> (After the first five interviews I became increasingly selective as to which categories I coded statements to.)

- Using the text editor it was then possible to copy and assemble all data relating to each category and sub-category so that these could be compared and interpreted.

#### **4.4.6. Ethical problems in the presentation of qualitative data**

Extracts from transcribed accounts are used extensively in subsequent chapters of this thesis to illustrate and support the discussion of the results of the study. This is one of the compelling features of qualitative research, since the respondent's own words frequently offer powerful descriptions of events and relationships. However, selecting and presenting these examples opens up a number of practical ethical problems that need to be considered here.

The first of these concerns the protection of respondents' anonymity and confidentiality. In my approach to potential respondents I gave an unequivocal assurance that the tape recordings of interviews would be held in absolute confidence, and that they would not be identified in the thesis or in any work that might arise from it. This is standard practice in most social and medical research and without such an assurance it would be difficult to conduct even quite routine studies. However, it does present problems where extracts from the transcripts are intended to be presented in the public domain. Clearly, the protection of the anonymity and confidentiality of respondents, patients and surviving relatives is of paramount importance and is not negotiable. In the extracts presented, nurses' names and some other details have been changed, and some clinical problems and other details pertaining to patients and relatives have been similarly disguised. There is a limit to the extent to which this can be done before an account becomes a piece of fiction, and where it has not been possible to do this without radically reconstructing the material, I have not reproduced the account.

The second problem with presenting extracts from a large body of data is that

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<sup>14</sup>Field defines a self-contained meaningful statement as 'any portion of meaningful speech which conveys at least one intended meaning', (1989:155).

this raises critical questions about whether these are typical of the data taken as a whole. As I pointed out in Chapter 3, accounts represent unique perspectives and contexts, and cannot be seen as being directly compatible or comparable with each other. In this sense, the question of whether they are typical is somewhat misplaced. What can be said about these extracts is that they represent common categories in the data. Again, this needs some qualification, since some examples have been presented because they represent striking examples of extreme or conflicting perspectives and have been selected on that basis. Where this has been done I have clearly indicated that this is the case.

Finally, a similar consideration applies to the question of whether examples have been presented in a way that maintains their intended meaning and context. I have tried to edit extracts in a way that ensures that these are not lost, and that the sense of an example is not changed. On a number of occasions this has meant the reproduction of lengthy items of reported speech, in order to represent as accurately as possible what the respondent seemed to be saying.

## CHAPTER 5

**'GETTING TO KNOW THEM': NURSING WORK AND THE  
CONFIGURATION OF THE NURSE-PATIENT RELATIONSHIP**

**5.1. Introduction**

In this chapter I examine respondents' accounts of the period in which the patient is admitted to the ward. In doing so, I introduce the central theme of the thesis: the ways in which social relationships between the nurse and the terminally ill patient are derived from nursing work which is directed not only at the body, but at the patient as an 'experiencing' subject, (Arney and Bergen, 1984). While respondents' accounts of patient care were dominated by the importance of 'knowing' patients, as a category of data this is neither self-evident nor unproblematic. Instead, it raises questions about what is 'known' about patients, the practices<sup>1</sup> through which this knowledge is produced, and the interests that it serves. I want to begin to address these questions by examining the period in which patients come to occupy a place on the ward and to be the focus of respondents' attention, in relation to respondents' accounts of what it means to come to 'know' them.

The staff nurses whose accounts form the basis of this study were concerned to emphasise that their work was knowledge-laden, and that the most routine encounters with patients afforded them opportunities to come to 'know' them in a more 'personal' way. We can see something of this in Strong's (1979) description of nurses working in a paediatric out-patients clinic.

They chatted away as they prepared a child for the clinic or guided parents to another part of the hospital. In doing so they gleaned a great deal of background information about the parents and their lives. Such detail was obviously of major interest to the nursing staff, but little use of it was apparently made by doctors. (1979:38)

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<sup>1</sup>I use the term practice to refer to both the acts through which encounters between patients, nurses and doctors are undertaken, characterised by Reading (1977:159) as, 'personal variants of normative behaviour;' and the 'knowledge or discourses which keep these actions in place (...) as part of the conditions of existence of these actions'. (Wickham, 1986:161).

This interest in 'background' information lies outside of the scope of Strong's study but at the centre of my own. In this and subsequent chapters I am concerned with the balance and direction of 'foreground' and 'background' enquiry by nurses, and with the ways in which these correspond to different kinds of nursing work. I should add that in this and in subsequent chapters I use verbatim extracts extensively. However, these are not intended to serve simply as illustrations to fill the spaces between my discussion of particular theoretical or practical points, but rather as an integral part of the text.

## 5.2. Doctors, nurses and clinical knowledge about the patient

In examining the formulation of nurse-patient relationships it is important to recognise the relative complexity of the organisational context in which they take place, and the ways in which the patient *qua* patient is defined both as an object, (ie. as a body) and as a subject, (ie. as an actor). The first point that I wish to make here is that as a *body* the patient is not 'known' to individuals operating in isolation from each other: but rather to groups of actors drawing on different resources in interaction with others. Because of this the patient may be defined – or socially constructed – in quite different ways by different actors operating in the same environment: as a matrix of signs and symptoms; the source of a cell culture; the object of a surgical procedure; a participant in a history taking interview; or as an administrative unit.

As a body, the patient is defined by its relation to the mobilisation of medical knowledges by a range of actors representing different professional groups and interests. This set of relationships has the effect of defining a set of organic features of the patient to be collectively addressed, and additionally it forms the basis of the order and arrangement of the patient's career as an administrative unit – the patient's relation to a bed or an appointment.

The second feature of the organisational context in which the patient is defined *as* a patient is that the knowledges on which this is predicated are not general but are specialised. As a profession, medicine is organised around groups focusing on specific areas of the body, and with discrete sets of knowledge and technologies through which the patient can be attended to. The increasing specialisation of medical knowledge and work is reflected in the proliferation of clinical departments within the hospital. The result of this, as Strauss (1985) has argued, is that the hospital has now come to resemble a set of workshops

organised around an intricate technical division of labour.

What medical staff know and do about the patient is critical to the configuration of nurse-patient relationships because of the ways in which the organisation and construction of nursing work reflects the authority of medical professionals to direct the form that it takes. Conflict and structural inequalities between medical and nursing staff - and the consequent subordination of nurses within the technical division of labour in health care - are a commonplace of sociological discourse about the hospital and its occupants. Clearly, these inequalities are important as they constitute the fundamental feature of relations between the two occupational groups. However, it also needs to be emphasised that these relations are also contingent and negotiated (Strauss, 1985). As such, they should be seen as being ordered round an arrangement of relative powers, rather than being constituted through an inflexible and deterministic set of relations. When we come to examine the ways in which knowledge about the patient created and possessed by medical staff is distributed to nurses, contingency is firmly located in the foreground of respondents' accounts.

CRM: You were talking earlier on about difficulties with the medical staff. How do they manifest themselves?

Nurse: One thing that happens is that when a patient arrives on the ward - our two sources of patient are A & E and coronary care - we have found that they aren't highly dependent on us, and shouldn't be with us.

And what we find is that the medical staff will bring us an uncomplicated myocardial infarction into the ward, and two days later they'll be moved out somewhere else, and two days later they'll find that they are boarded out somewhere else or sent home. So for that patient coming to us really isn't best for them - because they're being moved for the second or third time, and also they don't get the kind of counselling that they need - because they're being shunted from pillar to post.

We find we tend to be treated like poor relatives, in that we're not called through for ward rounds on occasions, and therefore there's information that is lost, and isn't passed on.

In this account the nurse emphasises that the definition of needs and appropriate locations of the patient within the hospital made by different professional groups may not coincide and are contested. The definition of the patient in relation to the different types of work undertaken by the two groups, and the unequal relationship between them, is also brought into the foreground by referring to the failure of medical staff to pass on clinical information about the patient, and the decisions that they have made as a consequence of this.

The failure of some members of medical staff to adequately inform nurses about the clinical state of the patient was an important feature of respondents' accounts, and it raises an interesting problem. In chapter 2, I suggested that the stereotyping of patients by nurses could be explained on the basis of their compliance or disruption of nursing work, and the extent to which they legitimated nurses' roles. Ideas about 'good' and 'bad' patients on which these stereotypes are constructed have their counterpart in the ways in which nurses categorise medical staff. The notion of 'good' and 'bad' doctors is an important element of nurses' accounts of their relations with them. I must stress that these categories do not refer to the ways in which respondents evaluated doctors' technical expertise or medical knowledge. Instead, they point to the power which medical staff have to disrupt nursing work by failing to incorporate nurses in the routines through which knowledge about the patient is constructed and distributed, and the extent to which they legitimate the nurse's role as a worker whose principal objective is to manage the care of the patient. We can see this exemplified in the extract below:

Nurse:

And there are occasions where medical staff will arrive on the ward and will not ask for a nurse to join in the ward round, and they will make decisions about patients – but because a member of nursing staff isn't there they don't pick up – *we* don't pick up what is expected. It gives everybody a very bad light as far as the patient is concerned, because it appears that the left hand doesn't know what the right hand is doing – *which does nothing for the patient's confidence in you as a professional.*

In the description above, the central features of 'bad' relations between medical and nursing staff are outlined. The failure of senior medical staff to include



nurses in the ceremonial of the ward round has two potential effects. First it disrupts the organisation of nursing work: nurses' access to knowledge about the work which they will have to undertake to put into effect medical decisions about the patient is radically depleted. In consequence, nurses are unable to mobilise their technical and administrative skills effectively. Second, it has a negative effect on the configuration of nurse-patient relationships by undermining patients' confidence in the nurses caring for them. As the respondent suggests, if senior medical staff do not legitimate the nurse's role, it is difficult to obtain this from the patient.

Nurse:

If the doctors do rounds - we've got quite a few consultants here, so it's all a bit bitty - they've maybe only got one or two patients to see on our ward at a time, so they could fly in and out and you'll never know that they've been, because you'll have been in with somebody else.

That's more of a problem. On the ward I was on before, we had just two consultants and you knew when they were coming to do a round, and you'd make sure that somebody went round with them. But here they tend to come round with the more junior doctors - see a patient and go away - and you don't know about it. So, it's up to yourself and the resident to get together and to make sure that you know what decisions have been made - invariably if a patient's going home it's the patient who says to you, 'oh, I can go home tomorrow' - and nobody's told you.

In this extract we can see how a basic organisational problem - the fragmentation of a consultant's client group, and its distribution across a number of wards - is resolved through negotiation between nurses and junior medical staff. The resident acts as a conduit for medical information about the patient which might otherwise be lost to nursing staff: but junior medical staff can also be the source of such problems. For nurses to deliver appropriate care to patients they must have adequate information to hand.

Nurse:

We're very lucky on the whole - the doctors are super! Sometimes you do come across the odd individual who has to be prodded and told, 'you really must tell us these things or they can't be

done'. Or, don't scream at us if they're not done and you haven't told us'.

For this nurse, problems over the distribution of information about individual patients and medical decisions about the form that their care should take can be successfully resolved through negotiation. However, there is still space for frictional problems:

Nurse: I think if they're told at the beginning - that we *have* to know - it's fair enough and hopefully they are. But it's like everything, a patient tells me today that they're going to theatre tomorrow and I tell them not to be silly, they've had their operation. But, in fact, during the ward round they decided to take him back to theatre but I didn't know that because the information hadn't been given to me. But medical staff on the whole are very good - consultants give you plenty of information - and if you ask them you're always more than welcome to discuss patients with them, their care and so forth.

Where medical staff are 'good' and enable nurses to have a full account of the patient's condition and its projected treatment, the pathways through which this information is distributed may be disrupted. 'Friction' in the transmission of this information comes about because of the ways in which the physical layout of the ward and the distribution of staff within them isolates individual nurses from each other.

Nurse: It's a question of whoever's in charge of the ward in the morning and does the ward round with the consultants having to relay the information. But if you don't have that information because you're occupied with another patient, sometimes you won't get to know until you get your next full report.

As this respondent suggests, problems of communications among nurses are critical because of this intermittent isolation from co-workers. This is emphasised in the account below:

Nurse: Generally I do get to know. And I would make it my business to find out if I felt I hadn't got information that I needed or whatever. And linear communication is always a problem on these sorts of ward, partly because we've got so many nurses on, people have days off and come back, there are doctors rounds coming in and out - perhaps you weren't involved in a particular doctor's round so the information has to be fed through other nurses. I think it goes through nursing generally, it's very hard to get information to and from the appropriate people.

The nursing process is intended to ease this problem by providing a systematic approach to the nursing care of each patient: and this involves a set of care plans - *pro-forma* on which all aspects of the patient's care can be recorded - and which are accessible to all staff. There are, however, some problems where this is not in place.

CRM: Do you think the nursing process has made a difference to the the sort of problems you get with information gathering and retrieval?

Nurse: In this ward the nursing process hasn't really hit us yet. In the paperwork we're still using the old Kardex system, with one sheet care plans, so there is no room to write anything on [them] for proper assessment and evaluation of the patient. But again, our new Charge Nurse is trying to get this changed - new paperwork etc, because all these things have been developed over the past two or three months.

Even where care plans are in use, the combination of poor relations between medical and nursing staff, and poor communication among nurses may generate a chaotic and stressful working environment.

CRM: What are communications like between nursing and medical staff.

Nurse: Very bad. Communications in general on this floor are very bad. Again it's the time factor. And medical staff tend to just tell somebody in a white dress, don't go and find Sister, or go and find the

senior person on that day. So quite often four or five nurses will know what's happening while the other two or three don't. You know, it's really just pot luck if things get back.

We do our care plans, but having said that they're not used really that effectively - again, it's the time factor, I mean it's a pathetic excuse - they're updated in the morning and again at lunch time, and when the night shift come on. So two or three times a day they are updated, but sometimes somebody's gone off with the knowledge about an examination or a prognosis or whatever, without writing it anywhere. Which is really very bad.

Sometimes you get it right. Sometimes you remember to tell somebody, and you know I'll write everything down either in the nursing Kardex, or in the care plan. So that I've done it when I'm told, because I tend to go off and do something else and completely forget what it was. But obviously, there's so many people using these care plans - the trained staff on my ward quite often don't know what's happening never mind the student nurses. The students complain to me quite often and say 'oh but we know nothing about what's going on' - nine times out of ten, I didn't know either.

Obviously, you have good days - if you're on for 7 or 8 days at a time you do get quite switched on to what's happening and you know what to ask and you know who knows what. But if you're just back from being on a few days off or something, you have 8 or 10 hours of (not knowing) and it's absolutely awful.

CRM:

So how do you cope?

Nurse:

By counting to ten frequently. I try very hard to be calm, I used to be the sort of person that got very uptight and rushed around trying to sort everything out - but now I'm very calm about it - I will listen to what I'm told, and I always try to document it, and in that way at least I'm not making errors. I'm sure I go off and I've forgotten something, but nine times out of ten it *is* written down. I try very hard to make sure that all my nurses know exactly what's going on. But having said that, there are times when somebody's out on the ward and they haven't heard maybe the last comment about Mr Bloggs you know. The way we are just now with staff shortages it's not often that one of the nurses goes on doctors' rounds even - and that's when this kind of information is being given - and you've missed it all. I just try and stay calm and try to

remember all that I'm told and document it. Maybe that's the way I cope.

This account raises a number of important issues. The way in which medical staff fail to take into account the needs of nursing staff and to differentiate between them, (by just telling 'somebody in a white dress'), rather than ensuring that information is passed through 'proper channels' adds to the highly contingent nature of the distribution of clinical information about the patient among nurses. Losses of information here are the result of the way in which relatively large groups of staff are mobile within their working environment and as a result not immediately available to pass on or to receive information. Contingency is important - people do simply forget to pass information on - but underlying this is the way in which the disorganisation of work, and the discontinuity of staffing on the ward exacerbates this problem. In units with a large population of patients it becomes more difficult for nurses to be fully informed about the status of individuals in their care.

Nurse:

Yes, when I worked in a radiotherapy unit<sup>2</sup> there were 54 patients on the ward. It was impossible to know exactly what was up with everybody. Obviously you knew if they were there it was a give-away that there was some problem, but having said that, I would say perhaps 50 per cent of them were in with very treatable cancers.

But you did really have to wander around thinking 'wait a minute, you look like a' it was really quite horrendous - because quite often you're getting it completely wrong. Sometimes on my ward now, when a patient's come in from casualty to the ward, the medical staff come in and walk off with the notes immediately. So you don't have a clue about anything to do with the patient for the first half hour, and it's sometimes quite a surprise - you go in and you talk to the patient - I had one man come in, looking jaundiced and he had enlarged testes and a swelling on the groin, and you think 'God, you look very like a cancer patient', and then you find you were right.

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<sup>2</sup>At another hospital

The issue of the distribution of clinical information about patients' conditions to nurses by medical staff is vital to any understanding of how nurses come to 'know' patients. First, because it is through this information that the patient is defined as demanding particular kinds of nursing care. A patient *is* an uncomplicated myocardial infarction, or a testicular cancer – because that is what medical staff need to know about him. As Wright and Treacher (1982) have pointed out, discourse systematically defines its own objects, and a good deal of attention has been paid to the ways in which medical discourse is organised around the reduction of the patient to a set of signs and symptoms. All medical knowledge about the patient – ie. about his status as the organic object of applied scientific enquiry and action – is predicated on this reductive process. Second, through the definition of the problematic nature of the patient as an organic entity, a potential career or trajectory is set out: the patient will go home in 72 hours, in three weeks, or perhaps not at all. The passage of the patient can thus be charted as an administrative unit demanding attention from a range of actors within and outside of the hospital.

What is striking about respondents' accounts of the distribution of medical knowledge, and about the practices through which this is accomplished, is the way in which these transcend the objects of discourse between doctors and nurses, (the administration of patients' signs, symptoms and trajectories), and focus on the nature of the relationships between them, and the ways in which these are worked out in practice. The quality of information provided by medical staff was not at issue. What was important, however, was the extent to which it was made readily available to nurses, and their incorporation in the processes through which it was distributed. It is worth also noting at this stage, that while problems about this were ascribed by nurses to medical staff being 'good' or 'bad' no such categories emerged in their accounts of their co-workers. Failures in communication between nurses were ascribed to the general conditions in which they worked, rather than to the 'interpersonal' relations between them. The significance of this should not be underestimated. Nurses come to 'know' about the patient as a biological entity in the context of their relations with a powerful group of medical actors who define the state of the body and project its career. The extent to which information is passed on to nurses determines not only the ways in which nursing work on the body can be undertaken, but also the possibility of disruption in the relations between medical and nursing staff.



Beyond the question of problematic relations between occupational groups, we also need to recognise the ways in which the organisation of nursing work, and the distribution of staff on the ward lead to nurses' contact with medical staff, patients and each other taking an intermittent form. Nurses are relatively mobile through the various rooms and bays on the ward, and interactions which take place between them and other actors are necessarily episodic – constrained by the demands of work to be undertaken at the next bed or elsewhere on the ward. The consequence of this is that the processes through which nurses come to 'know' about patients are neither sustained nor do they proceed in a steady linear progression. Instead, they are organised around a fragmented, discontinuous and contingent set of encounters. Within these, the nurse obtains information that is collectively manufactured and evaluated by a relatively large group of actors. But while medical knowledge about the patient is constituted primarily through reference to physiology and to the material practices that doctors and nurses can activate to respond to the organic, nurses accounts reveal that they are at the same time involved in practices through which they come to 'know' the patient in ways which involve the constitution of the patient as more than an organic focus for work. In the following discussion I will examine this productive side of the nurse-patient relationship in more detail.

### 5.3. 'What are they like at home?' Coming to know the patient

While accounts of the way in which patients come to be 'known' to nurses as the objects of clinical attention are centered on nurses' relationships with medical staff, accounts of the ways in which patients come to be known in other ways centre on the conduct of particular kinds of nursing work. On admission to hospital the patient becomes the focus of attention through which nurses attempt to establish a 'social' history which parallels that of her clinical condition. At the time of her induction onto the ward this enquiry may be quite formal: the introduction of the nursing process has led to a proliferation of *pro forma* on which biographical information may be collected and stored. The purpose of much of this information is unambiguous: it charts the patient's access to particular material and social resources, as well as details required for administrative purposes – which relative to call in an emergency, or whether the patient might wish to be visited by a hospital chaplain. Additionally, the extent of the patient's awareness of the nature of her

condition and the degree to which close relatives have been informed about this may also be explored. As we shall see in subsequent chapters, the extent of patients' knowledge about their disorder is of great significance in the way in which nurses act during encounters with them, but for the moment I am concerned with the ways in which nurses come to know the patient before any diagnosis or prognosis is reached.<sup>3</sup>

Beyond the formal enquiries undertaken during the patient's admission interview, respondents stressed the ways in which they attempted to know more about the patient than the simple biographical information required for ward records. This information falls into two main categories: about the patient's relationship with others, especially his or her family; and about 'normal' modes of behaviour. This information has little obvious clinical value, except, as in the extract presented below, to nurses engaged in the care of patients with neurological deficits.

Nurse:

Sometimes patients will just not tell you anything no matter how much you sit and talk to them or whatever – and sometimes the information has to come from a third party – the husband or son or daughter. You see, the trouble on this ward is that people will come in with tumours and nine times out of ten it will alter their personality, even if it's only very subtle. You think, 'I wonder what they were like before they came into hospital?' And sometimes they aren't really capable of giving an accurate past history, so therefore you have to go to the relatives for that information.

In this account we can see the intermeshing of clinical and social histories and the use of third parties as sources of information from which a picture of the patient can be built up. But an interest in the patient as an active and independent figure beyond the institutional boundaries and relationships of the hospital has a practical value in establishing the parameters of her normal routine.

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<sup>3</sup>An example of a pro forma on which this type of information is collated may be found in Binnie et al (1984:40). A number of different kinds of form were used by respondents in this study.

CRM:

So, what kinds of information are you after?

Nurse:

I suppose, basically, what they were like before they came into hospital, so that we can try to maintain as normal [routine] as possible - I don't feel that by coming into hospital that an individual should change their life drastically I try to work round patients a bit more. We have a man in just now who at home - he lives alone - he doesn't eat after 6 o'clock and he just has tea and a sandwich then. And we just plonk down a three course meal at 6.30 and say, 'oh no, he's not eating'. But the man doesn't eat at that time at home, he just *doesn't*. He's not used to that. I always say to them, well, what do you do at home? And try to keep it as normal as possible for them, because it must be really abnormal coming into hospital in the first place. and I try to keep some sort of reality in their lives during their stay.

This respondent points to the way in which the patient's immersion into the social apparatus of the ward demands of them substantial rearrangements and adjustments. Although the ward is a highly routinised environment it is possible to concede to the patient some control over the way in which his daily life is ordered. In this case, understanding the way in which a particular patient orders his daily routine outside of the hospital explains what in other circumstances might be construed as a sudden loss of appetite or non-compliance. In this account we can also see an underlying conflict which runs through the arrangement of the hospital: it is at once a residence for groups of patients, and a workplace for its staff. For long-term patients, or the chronically sick, the ward may genuinely become their place of residence:

CRM:

I imagine that you get to know some patients quite well?

Nurse:

You get to know *them*, you get to know their *families*, you get to know *every aspect of their lives*. The ward *does* become their life - and they also rely on us to sort out their home problems: they may need to be re-housed and that's got to be done through us. Any social work care, and back-up, is done through the ward. So you get to know people very well.

But some patients I know nothing about them - you see people coming in to visit them, and you

just don't know what kind of life they've got or what they do.

This account exemplifies the ways in which 'knowing' the patient is actually the focus for particular kinds of work: beyond the accumulation of symptoms which define the patient as the object of clinical attention, specific problems outside of the hospital may need to be resolved if they are to return home - and responsibility for initiating this process lies with the staff nurses on the ward. In the following extract we can see a similar set of characteristics:

**Nurse:** I like to know their home circumstances. Do they have a spouse still living; do they live on their own; what sort of social circumstances do they have. Just to put a hat on it. I also like to know whether they've been in hospital before. As I say, quite a lot of our patients are chronically sick, so they're coming in and out at various times during the year with relapses, and then they go into remission again. But having said that, I do learn all this throughout the time they are here. There's very little that I don't know about them after they've been in for a couple of weeks, and normally during the first few days you're picking up everything.

This line of 'personal' enquiry, conducted episodically during the period in which the patient is settling in to life on the ward, clearly has a value to the nurse in respect of the arrangement of work. However, while the collection of information about patients is important, it has effects which respondents saw as valuable and rewarding for both themselves and their patients.

**CRM:** If you had to pick out the major strengths of working on this ward, what would they be?

**Nurse:** Probably the good rapport with patients. Because we do keep patients longer we do get more involved, you get more involved with families and with the patients themselves and I find that quite rewarding. I like having a lot of contact with patients - and with the setting that they come from. You know, quite a lot of nurses set the nurse-patient relationship very much in the clinical area. I like to get the picture of what they've been

like at home so that they *are* Mrs Jones or Mr Smith – you know – they're not the third bed on the left sort of thing. So I would say that it's the opportunity to have a good rapport with patients. And you're giving them a lot of back-up when they're coming in and going out – a lot of them with leukaemia need a lot of support.

Another respondent was concerned to stress the moral imperative to 'know' patients.

Nurse:

I think you've got to get to know the patient – when you're interviewing them when they come into hospital you ask them all about their family background, their home life, who they live with, if they have children, if they don't, if they're married – whatever – interests.

You give them a bath, you say – did you see such and such on the television – they say, no I don't really like that sort of thing. And there are weird long drawn out conversations. You just get to know what they're like, what sort of life they've had, what their likes and dislikes are – and different people will talk to you more readily.

In the preceding extracts we can see how 'knowing' the patient extends beyond the formal demands of the bureaucratic administration of patient care. As the object of clinical and administrative work, the patient is known in a context in which different groups of professionals organise their work around its public features. In this sense, the patient as a body is constituted by knowledges and practices that are mobilised in an arena in which collective action is undertaken. As I have already noted, these knowledges and practices are reductive: they have the effect of constructing a set of categories in which the patient is located as a *type* of body – geriatric, cardiac, recovering, terminal. As such, they disconnect the patient as a subject from the sphere in which they are deployed, concentrating instead on the patient as the focus of knowledge and as a *site* of action.

In the micro-context of encounters between nurses and their patients these clinical types are conterminous with categories which define the patient's

relationship to nurses and their work. As I noted in chapter 2, patients are stereotyped according to their power to disrupt or comply with the demands made on them by the social arrangements of the ward in which they are located. Coming to 'know' the patient is not only the process through which these categories are constructed, but it also has the contradictory effect of undercutting patients' status as objectified members of categories by establishing them as subjects participating in social action. Here, a 'good rapport' with the patient offers the nurse more than a satisfying or rewarding milieu in which to mobilise technical knowledges and practices. It also sets out a semantic space (Reading, 1977:198) in which the meaning of nursing work can be located, and in which ideological notions of what nurses do can be enacted. In this sense, getting to know the patient is about the mobilisation of what one respondent called the nurse's 'traditional, listening, caring' role.

#### **5.4. The unequal configuration of the nurse-patient relationship**

Although I observed at the beginning of this chapter that 'knowing' patients cannot be considered to be a self-evident category in respondents' accounts, I have so far left the question of 'knowledge' relatively unelaborated, and have taken a self-consciously 'administrative' line in charting the contours of nursing work as it addresses the patient, and as it emerges in the everyday typifications through which accounts are formulated. 'Knowing' patients implies both a process and a state, in which the patient is defined as an actor and as a body through encounters in the workplace. My objective in this chapter has been to emphasise the primacy of nursing work as the constitutive basis of the nurse-patient relationship. By looking at the period in which the patient enters the ward, we can see the emergence of two distinctive and knowledge laden spheres of nursing work.

First, nurses undertake work that involves the mobilisation of knowledge about the patient which is collectively generated. In this sphere of material practice the patient is 'known' through the application and interpretation of medical knowledge about the body, and the patient is addressed through procedures which define her biological state and the possibilities for her normalisation. The essentially reductive power of medical knowledge has the effect of constituting the patient as a set of more or less problematic pathological categories, and is underwritten by an extensive and pervasive set of power relations.



In contrast to the reductive power of medical knowledge and practice, I have pointed to the ways in which nurses come to know the patient as more than an organic object, and the great effort that appears to be devoted to this. Enquiries about the patient as an actor independent of the hospital – with a history in which are embedded relationships with other actors and institutions, and possessing individual qualities – have effects beyond the formulation of information to meet the bureaucratic demands of the hospital. Within this work, the nurse comes to 'know' the patient as a private subject.

This subjectification of the patient, through a set of productive capacities embodied in nursing work, also involves the exercise of power. But while the power to define the patient as *more* than a clinical problem lies with the nurse, it is important to recognise that the patient is not powerless. As the subject of enquiries about her history and qualities the patient has the power to resist, and in consequence to *not* be known. The question of legitimation is crucial to this: as May and Kelly (1982) have shown. And as we saw in a number of the extracts presented above, the patient is not always 'known' to the nurse. But even where the patient does legitimate enquiries about her social history, we should not see this as in some way democratising the relationship between her and her nurses. The nurse still retains control over the form that interactions take, and one of the interesting features of the accounts which I have presented in this chapter is the absence of a reciprocal exchange of personal information between nurse and patient at this stage in the patient's career. In chapter 2 I surveyed a body of literature which describes the repertoire of practices through which nurses manage and control their encounters with patients, but as Gordon (1981) has noted – in a discussion of Foucault's concept of power-knowledge<sup>4</sup> – power need not be seen as the effect of a repressive or coercive apparatus; and *control* is important in the context of specific encounters. We can see this exemplified in the extract below.

Nurse:	I think one of the most important things is to let them know – because what brings a patient into hospital, it's a traumatic time for them, a very worrying time for them – is to let them know that
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<sup>4</sup> I discuss Foucault's notion of pastoral power as a basis for particular encounters between nurses and patients in greater detail in chapter 9.

you are in control of what is happening to them.

So if there are bits of machinery bleeping or buzzing, it gives them confidence that you know what you're doing. That can come about in various ways, just by talking to them, not looking harassed – whether you are or not – taking the time with them and settling them into the ward, making sure that they have everything they need, making sure they have a system whereby if they feel they need somebody quickly they've got the possibility to do that.

I think that the patient's got to feel that if they're not in control then somebody they can trust *is* in control. You have to be able to gain that trust very quickly, and it is a very difficult thing to do. Especially if you have patients who all need to be looked after at the same time.

In this account the respondent explicitly links the question of patients' perceptions of nurses' control over their *situation* with the establishment of relationships with them. The nurse represents the institutional goals of the hospital, (and the much broader set of powers and knowledges that are focused through it), but this is clearly more than the manufacture of a set of conditions which underwrite specific modes of interaction. It is about work which is undertaken to meet a highly specific set of objectives, and in which technical competence in its material practice is intimately connected with the activation of personal sympathy – not only as the *mode* through which this work is delivered – but also to underwrite the structural inequality of powers between nurse and patient.

At the outset, then, the relationship between nurse and patient is associational: by which I mean that it is oriented around a set of objectives which are defined through the power of one set of participants. It rests on the nurse's legitimate authority to work on the body. If by this point I have rather laboured the point that the patient is first and foremost a body, (albeit a particular body), this is because it is precisely the body which is the central focus of biomedicine – as Foucault demonstrates in *The Birth of the Clinic* (1973).

The *object* of discourse may equally well be a *subject*, without the figures of objectivity being in any way altered. It is this *formal* recognition, *in depth*, rather than the abandonment of

theories and old systems which made the *clinical experience* possible. (1973:xiv) <sup>5</sup>

The central point here is that the social character of the patient is more or less incidental to the nature of the technological practices through which he or she is defined as organically disordered, (although not to the nature of the social interactions through which these are mobilised, in which class, gender, race, and so forth may play a vital role). Of course, this position is not confined to Foucault. The disconnection of the patient's organic and social character through the mobilisation of apparently asocial and neutral scientific medical knowledge has been a relatively constant feature of discourse *about* medicine since Parsons. But while the relationship between medical staff and patient is characterised by a distant formality and ceremonial which at once identifies the doctor as the embodiment of a particular set of knowledges and capacities through which this disconnection may be undertaken – the relationship between nurse and patient is characterised by attempts to bring object and subject together. This imperative for reconnection lies at the background of the thrust towards the individualisation of patient care which underpins the accounts in this chapter, and the more rhetorical and theoretical material which I have touched on in chapter 2.

'Knowing the patient', then, is problematic: respondents' accounts reveal an intertwined set of practices – undertaken in a discontinuous, episodic and contingent form – through which different knowledges about patients are constituted. These have three clear effects, in that they: define the contours of an organic disorder; chart a 'social' history of the patient as an actor outside of the hospital; and locate the the patient as an idiosyncratic actor in a matrix of social relationships on the ward.

While these practices are undertaken by individuals, it is important to recognise that they meet the needs of, and are undertaken in the context of, groups – professional and otherwise – and draw on particular collective resources. As

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<sup>5</sup>Here, Foucault is speaking of the radical shift in the nature of medicine in the latter part of the eighteenth century, from physic which relied on an account of the patient as an individual constituted both by object and subject, to the clinic as the site of a rationalised scientific discourse about the general features of the body as an anatomical object.

Barnes (1977) has argued:

Knowledge is not produced by passively perceiving individuals, but by interacting social groups engaged in particular activities. And it is evaluated communally and not by isolated judgements. Its generation cannot be understood in terms of psychology, but must be accounted for by reference to the social and cultural contexts in which it arises. (1977:2)

I wish to turn now to the question of 'knowledge' and 'power' more directly, as the mode through which relationships between nurse and patient are effected. While the initial point of contact between the nurse and patient is characterised by the deployment of technical knowledge about the status of the body, we have also seen that nurses are concerned to undertake lines of enquiry that expose the social character of the individual patient and which reveal them as 'experiencing persons', (Arney and Bergen, 1984). While the body remains the central focus of the material practice of nursing work this interest in the social character of the patient and the moral imperative to *know* him or her as a *person* needs to be examined.

Building on the work of Michel Foucault, Armstrong (1983b) and Arney and Bergen (1984) have pointed to a shift in the ways in which medical knowledge and practice are directed at, and apprehend, the patient. Here, as Armstrong has argued, the patient is no longer confined to identification as a physiological case, but is now open to examination as a social case whose surveillance by medical professionals and para-professionals reveals biographical factors. Gerhardt (1989:324) has asserted that this means that 'problems of living have come to be incorporated into the the realm of medical management'. She goes on to argue:

now the patient comes to matter as one who feels pain, or experiences satisfaction: that is, as the person in his or her entirety of previously clinically irrelevant identity. Through the incorporation of person-related aspects, mirrored in how medical care is received and experienced, the realm of what comes under medical control is broadened considerably. (1989:325)

Nurses are ideally placed to undertake this work, and we have seen in some of

the accounts presented in this chapter that clinical and social histories are intermeshed in respondents' accounts of 'coming to know' patients and are directed not only at their problems of living, but equally, at their problems of living *in* hospital. In this sense, coming to know the patient as an inhabitant of the ward may be seen to be an explicit strategy of surveillance, and indeed, Bloor and McIntosh (1990) have observed that surveillance is a necessary precondition of therapeutic work. In their discussion of the mode of surveillance activated by staff in a therapeutic community and by health visitors on domiciliary visits, Bloor and McIntosh have argued that:

there is a therapeutic gaze which parallels Foucault's 'clinical gaze', a gaze which observes and interprets residents' behaviour and constitutes residents as psychosocial beings with 'needs', 'motives' and 'problems'. (1990:169)

Here, surveillance of the social exactly parallels the observation of the body that has historically constituted an important element of the material practice of nursing work. At the same time, unlike the observation of the body - 'coming to know the patient' as a subject - offers her the opportunity of resistance and of thus remaining *unknown*. Whether we view this as a question of legitimation and non-compliance (May and Kelly, 1982), or of surveillance and concealment (Bloor and McIntosh, 1990) it has the effect of closing off the field of nursing work in which the patient is established as a subject.

In this chapter, we have seen how the patient comes to be 'known' to nurses through active enquiry that arises directly out of, and is intimately connected to, nursing work. This enquiry defines the relationship between nurse and patient by setting out those features of the patient's social and organic character which are the focus of work. At the same time it has the potential to undermine the categorisation of patients according to *types* and so opens up the possibility of personal and diffuse relations between nurses and those in their care.

**CHAPTER 6****'YOU JUST HAVE TO BE DIPLOMATIC':  
KNOWLEDGE ABOUT THE PATIENT AND  
THE MANAGEMENT OF UNCERTAINTY****6.1. Introduction**

In chapter 5 I explored the connections between the configuration of nurse-patient relationships and nursing work organised around the formulation of knowledges about the patient. I argued that the patient comes to be 'known' to nurses not only as an object of clinical attention but also as an active subject, and is constituted at once not only as the focus of nursing work but also as an inhabitant of the workplace. In this chapter I am concerned with the ways in which knowledge about the body is managed during that stage of patients' careers in which disorders come to be defined as lethal. In this period not only is the nature and extent of a specific disorder uncertain, but the configuration of nurse-patient relationships is characterised by the pragmatic negotiation or management of these uncertainties. I address three spheres of nursing work in which this negotiation is undertaken: nursing work directed at managing the patient's own attempts to possess information about the state of his body; the collection and deployment by nurses of medical information which defines the presence of a lethal disorder; and the ways in which nurses respond to the practices through which decisions are made about the disclosure of terminal prognoses to patients.

In practice, the sequential distinction which I make in this chapter between these three spheres of nursing work is not so clear cut, and this depends on the trajectory of a specific disorder. Shifts in patients' status may be quite incremental in character and undertaken over a period of several days, (or even weeks), while in other cases the sequence of events may run very quickly and take a dramatic form.

**6.2. Diagnosis, prognosis and uncertainty**

In the period before a firm diagnosis is reached by medical staff, the nurse is intimately involved with the production and administration of medical



knowledge about the patient. Before examining nurses' accounts of the ways in which this is undertaken, the distinction between 'terminal' disease and 'dying' needs to be clearly identified. Although some respondents employed these terms interchangeably, others used them in a specific sense, and they refer to different biological and social processes and events.

A disease is defined as terminal when it involves an abnormal biological disorder which will ultimately cause the cessation of life, and for which no medical intervention is available that will effect a recovery or restoration of the body. The definition or diagnosis of a disorder or complex of disorders involves the mobilisation of scientific knowledge about the the body which is necessarily general: that is, it is about *bodies* rather than a specific body.

Diagnosis involves the interpretation of this general medical knowledge in terms of the effects, trajectory and the range of possible responses to a disorder. However, this knowledge is about the *potential* of the disorder within the specific body, rather than its absolute predictability. In the case of some disorders, (some leukemias, for example), the exact course and duration of the condition cannot be charted with any precision, and there is always the possibility of either retardation through medical technologies, or of spontaneous remission. So although the presence of particular signs and symptoms may lead to the identification of a disease, prognosis – a judgement about its effects and trajectory – remains uncertain in any immediate sense, although at a general level it will be known to be ultimately lethal.

The potential of death represented by the diagnosis of a 'terminal' disorder and the prognosis of its effect on the specific body should not, however, be equated in any direct way with *dying*. The trajectory of some terminal disorders may encompass months or years: so a biological definition of dying needs to be ordered around the relatively distinctive final phase of a disorder in which the catastrophic failure of the body's physical systems takes place. Again, the duration and trajectory of this phase is uncertain and unpredictable (Strauss, *et al*, 1968). This is marked either by the destruction of vital organs or systems to a point at which they cease to be viable (in the case of cancers of the liver or brain), or by their failure (in the case of cerebral haemorrhage or AIDS). The clinical trajectory is complicated by the way in which the existence of one disorder may lead to secondary causes of death (Prior, 1989). Chronic degenerative conditions of the lungs, such as Emphysema, may lead to

pulmonary heart disease or to broncho-pneumonia, and these are the immediate cause of death (Prior, 1989; Bloor, 1989).

As medical knowledge about the state of the body and the trajectory of its organic crisis is produced, the patient comes to occupy the centre of a potentially dramatic set of social arrangements. It is important to emphasise at this point that for the patient – until medical staff formally disclose their prognosis – the experience of hospitalisation is characterised by social dislocation. Patients are isolated from their normal matrix of relationships and dislocated from their familiar physical surroundings. The new and unfamiliar routines and practices that they encounter in the hospital will inevitably involve a much more tightly regulated regime, and the loss of independence that is consequent upon a debilitating illness is compounded by the loss of personal autonomy experienced by the patient.

While the patient's transformation from an independent social actor to the dependent object of administrative procedures and medical practice, is characterised by different forms of social loss, it is also characterised by profound uncertainties. The meaning of specific tests and procedures may be quite unclear to the patient, the apparent absence of definitive knowledge about the trajectory of the body, (and the power relations articulated in interactions between the patient and those who might possess that knowledge), emphasises the strangeness and uncertainty which surrounds the patient.

In these circumstances patients and their relatives inevitably become suspicious and anxious about the disorder and what it might mean. Although these suspicions may not be explicitly articulated patients do direct questions or cues at nurses. How nurses respond to these 'awkward questions' is problematic: since they are subject to an elaborate construction of moral pressures not to undermine or pre-empt the doctor's position as the source of authoritative knowledge about the body and of its disclosure to the patient, although they may be aware of the patient's diagnosis and its implications. Prior to disclosure, the nurse is intimately involved in controlling the medical information available to the patient, and this demands considerable investment in social skills. The management and control of this information is vital, not simply because of the uncertainty that may surround the patient until medical staff have reached a definitive prognosis, but also because even once this is reached there may be disagreement among medical professionals about

whether patients *should* be told, and if they are, how this is to be undertaken (Bennet, 1979; McIntosh, 1974; Knight and Field, 1981; Field, 1989).

### **6.3. Gate-keeping and mediation: managing access to information about the body**

Nursing work directed at uncovering the implications of a disorder may continue up to, and beyond, its disclosure to the patient. Although the procedures through which knowledge is constructed about the form and trajectory of the specific disorder are owned and controlled by medical staff (to whom nurses have privileged access), patients and relatives are not passive, and are actively concerned to possess this knowledge for themselves.

**Nurse:** A patient asks if they have cancer – that's probably the classic example anyway. Because invariably the medical staff will maybe say that you either have a polyp or an ulcer – which usually means a tumour. Now, you have to make a special note somewhere that the patient is unaware of their diagnosis. Just purely so everybody knows, so nobody puts their foot in it. Plus, the doctor is usually able to say immediately after the operation whether they think it's a tumour, and in some cases it's well defined as a tumour anyway – but the biopsy results take seven or ten days to come back – so really within that time you're better off (not) saying – purely because you haven't got the biochemistry results back – until you know whether it actually is cancer or not.

At this stage – between diagnosis and disclosure – the nurse acts as a gate-keeper or mediator between patient and medical professionals. This involves work directed not only at maintaining and observing the body, but at controlling and managing the patient's access to information about it.

If a definitive prognosis of the trajectory and effects of a disorder has not been fully constructed by medical staff, nurses' responses to requests for information require sensitivity and caution. The accidental provision of incorrect knowledge, or the unintended disclosure of a terminal prognosis, may be traumatic for the patient *and* disrupt relations between nurses and medical staff. However, patients may also be alarmed by the absence of information

about their condition and suspicious about what this might mean. For the staff nurse, who is in more frequent contact and closer proximity to the patient than medical staff, this situation is demanding and problematic. Staff nurses' accounts reveal three main strategies for responding to 'awkward questions' and mitigating patients' lack of access to information about their bodies without undermining the authority of medical staff.

The first of these - *deflection* - is oriented around resisting the patient's enquiries.

Nurse: It's difficult - there's no doubt about it - until they [the medical staff] have the results back on paper they don't normally tell them. It's normally the case - (and) it's terrible - of your telling them that you're waiting on tests to come back, although you may know the results already. You have to *lie* until they actually decide that they are back on paper, so you're constantly fobbing people off, which isn't very nice.

In this account the nurse emphasises the demand for definitive knowledge about the patient: only when this is properly constituted in documentary form is it possible to consider 'telling' the patient. The need for caution and sensitivity is emphasised in the following extract, where there is real uncertainty about what particular signs and symptoms precisely mean.

Nurse: It's quite difficult to cope with, especially if someone comes out with, 'have I got cancer?' You've just got to be diplomatic and say, 'what's the point of worrying until the tests come back, wait and see?' It's complicated, I never would turn round and say, 'you haven't got cancer'. You have to wait and see because you never know what goes on, sometimes they think they're benign when they're not - you have to be careful.

Deflection is a delaying tactic, defined either by uncertainty about the patient's prognosis, or by uncertainty about its delivery. Although it is a stressful accomplishment and demands a great deal of the nurse, it is predicated on the possibility that the patient *will* be told at an appropriate moment. In this sense,

it needs to be carefully distinguished from Glaser and Strauss's notion of 'closed awareness contexts' (1965b) which operates on the assumption that terminal prognoses are concealed from patients throughout the duration of their disorder.<sup>1</sup>

Although patients may be suspicious about their condition or alarmed by a lack of information about it, (and the lack of an underlying reassurance that they will recover), they may also be profoundly uncertain about the focus of this attention at the body. That is, they may simply not understand what is going on. The second strategy to which respondents referred - *reflection* - is organised around the careful definition and partial affirmation of these suspicions.

Nurse: It hasn't happened to me on this ward, but certainly on other wards I've found patients basically sussing me out and asking me, 'well I don't feel as though I'm getting any better nurse'. That sort of thing.

Even if they haven't actually been 'told' by a member of medical staff I would certainly encourage them in their questioning and say, 'well, you don't seem to be getting any better do you?' You're usually affirming their suspicions.

Through this strategy the patient's demand for information is affirmed rather than resisted. Where deflection involves deferral of enquiries to the hidden processes of the pathology laboratory and to the 'tests' that are conducted there, reflection revolves around referring questions back to the patient. In the following extract a nurse explains the rationale for reflection.

Nurse: Because I think patients *know* and often they don't want to ask because perhaps they don't actually

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<sup>1</sup>Although the formal concealment of prognosis may not preclude the patient being aware of it. Glaser and Strauss point to the ways in which the behaviour of medical staff may itself provide the patient with cues about his or her condition, despite efforts to conceal this. Knight and Field (1981) have observed that in a surgical ward where closed awareness contexts were the norm, very few terminally ill patients were unaware of their terminal condition in practice.



want to deal with the information themselves, or they feel that their relatives can't deal with the information.

In a sense, reflection relies on patients to sustain themselves, they are assumed to 'know' secretly or subconsciously, but not to articulate this knowledge. The perceived benefit for the nurse is that such an approach to the patient may lessen the shock of disclosure, but what one respondent characterised as 'sowing the seeds of doubt' also involves some risk. It does undermine the authoritative position of medical staff, and it does hint at the nurse's possession of information which, given the uncertainty which surrounds some prognoses until the last moment, may alarm or convey the wrong impression to the patient. For these reasons, reflection - like deflection - demands caution and sensitivity. There may be other reasons, of course, for reflective tactics when the nurse is responding to 'awkward' questions.

Nurse:

I've never been in the situation where somebody has asked me outright whether they have a terminal illness or whether they're going to die. I've definitely been in situations where the patients themselves have dropped hints, which I've usually picked up as being they don't really want to know but which they have really left open. Having said that, that can be another way of saying that I'm evading the actually having to tell them, and ultimately it's not my responsibility so, you know, it's a kind of evasion. I've certainly been in situations where people have prodded and that would be a case for, you know, asking the patient themselves what they think. And some people respond to that and some people don't - not if they don't want to know.

In this account, the nurse emphasises the importance of the patient *really* wanting an answer to these questions. Reflecting it back to the patient forms a filter for problematic encounters which both defends the nurse against difficult situations, and protects the patient from the distress of confronting issues that they would rather avoid. But at the same time, this respondent recognises that her motives might be ambiguous, resolving that problem through the notion of responsibility. If she is not responsible, in terms of the technical division of



labour between medical and nursing staff over disclosure, then her involvement in this kind of exchange is itself voluntary and may be avoided or terminated.

The third strategy through which nurses respond to patients' demands for information about their condition – *mediation* – revolves around making the arrangements necessary for disclosure. Instead of deflecting or reflecting patient's enquiries, the nurse acts decisively to bring doctor and patient together.

Nurse:

You just try to talk to them and see what they feel is wrong, and if you really can't answer their questions – what most of us do is to go and see the doctor (and) make an effort to get the consultant to come and talk to them.

Mediation is a true gate-keeping strategy: the nurse acts as an administrative link between doctor and patient, making the arrangements to have the patient informed of his or her prognosis. However, a mediating strategy can only be effectively undertaken if the nurse is confident that medical staff are willing to disclose prognoses, and as we will see, this is by no means always the case. It is also important to distinguish this tactic from the doctor being brought into the ward to prevent patients from worrying unnecessarily about their illness: in the account above, the nurse is deliberately focusing on patients for whom no such reassurance can be offered. In both cases mediation between doctor and patient acts to end the patient's uncertainty.

The effect of gate-keeping strategies is to manage patients' uncertainties through controlling access to information about what is currently known about their disorder and its effects. Because nursing staff may themselves be highly uncertain about this, the nurse represents herself as dependent on knowledge constructed and mobilised elsewhere, (in the pathology laboratory, by the patient herself, or by the doctor). This dependence on the authoritative knowledge of others is organised through an emphasis on the structural inequalities of power and knowledge between doctors and nurses and acts to block, rather than resolve, patients' enquiries. In the case of terminal illnesses, it can only be seen as a delaying tactic, since – at some point – admitting the terminal nature of the disorder is inescapable.

Encounters in which nurses employ gate-keeping and mediating strategies are organised around a problematic configuration of the nurse-patient relationship during which nurses may know more about the patient's condition than they feel able to concede. But while the status of the body may be in doubt – as may its explicit disclosure to the patient – accounts of these encounters reveal more than a set of techniques through which the patient may be restrained. Patients' enquiries about their disorder also expose their desire to *know* about this, and the degree to which they are aware of the potential effects of their condition. The consequence of this is that patients come to be 'known' to nurses not only as historic actors outside of the hospital or as its present inhabitants, but also in terms of their potential. Questions about whether the patient should be told can thus be answered on the basis of cues that they have already given about whether they wish to know. This information is clearly of critical importance in decisions about the form of disclosure which can be made to the patient: the extent to which medical staff make use of it is, of course, a further problem.

#### 6.4. Uncovering prognoses

While the delivery of the prognosis to the patient may be in doubt at this stage, its delivery to nurses is vital because of the ways in which it will determine their work – not only in observing, maintaining and administering the body – but because of the work which nurses direct at patients as social actors. Although communications between medical and nursing staff may be disrupted and fragmented for the reasons that I described in chapter 5, the delivery of medical information about patients' diagnoses and prognoses to nurses was seen as relatively unproblematic by most of the respondents in this study.

Nurse: Well, on admission if they've decided that there's something suspect they'll go for the relevant tests. Then an oral communication comes back from the medical staff, (and) they let us know what the prognosis or diagnosis is.

In the case of transfers within the hospital or of patients who have been under treatment prior to entering hospital, the question of diagnosis and prognosis is

much less problematic. While the construction of prognoses is firmly in the hands of medical staff, nurses are by no means dependent on the provision of medical knowledge about patients by doctors. Nurses also 'know' about the body and make inferences from the signs and symptoms visible to them about the potential meaning and significance of the patient's condition.

Nurse:

They're often admitted with us knowing that [their prognosis is poor,] because they're often admitted having attended radiotherapy or wherever for treatment and then they have developed a fracture<sup>2</sup> and therefore they've come to us for pinning or whatever of their fracture. And they've made progress and gone home, and come back, or they may never have recovered sufficient strength to go home.

You're suspicious if its a fracture, it probably hasn't taken very much trauma to cause the fracture. So someone else comes to you with a fracture and they didn't fall, then you get suspicious. So you're looking for something immediately. So from the minute of admission you maybe don't know; but you're suspicious.

Nurses' knowledge about the body is distinguished from that held by medical staff not simply by the extent of its technical detail, but by the modes through which it is operationalised. While medical work involves diagnosis and intervention, nursing work revolves around observation and maintenance. This distinction between diagnostic and observational knowledge about the patient emerges clearly in the extract which follows. Here, the delivery of detailed clinical information about the patient is paralleled by the nurse's own assessments of the patient's condition.

Nurse:

You can see if a patient is unwell and sometimes you can tell with a patient if they're not going to survive, but probably the more experience that you have - you can tell if a patient isn't going to make it. We had a chap in recently who was very, *very*

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<sup>2</sup> A pathological fracture caused by the weakening or destruction of bone tissue by a tumour.

unwell - and he's now sitting up feeding himself, and hopefully he'll go home. We were all proved wrong, but he was very unwell indeed.

This account opens up the uncertainty of predictions about the trajectory of specific disorders. However, the condition of the patient and the potential implications of a disorder, are not always immediately visible to nurses. In consequence, while the activation of specific tests or investigations offers nurses a set of clues about the possible future of the patient, the revelation of a terminal prognosis may be sudden and unexpected.

CRM: How do you normally find out if a patient has a poor prognosis and is expected to die?

Nurse: Through the medical staff. Again, it would be following an operation because that's the type of ward I'm on. They would come back from theatre having had a Laparotomy - and it would just say on the sheet Laparotomy - and if it just comes back with Laparotomy, you would want to know why because they were planning to do something else. And then sometimes you have to ask, sometimes they'll tell you. Just like, it was an open and shut case, because there was nothing that they could do when they went in.

Therefore you have a good idea. Usually what they do is visually identify if there are liver metastases - which obviously means someone's got a poor prognosis anyway. Or else it'll be the biopsy again - but until we have the biopsy back you can't definitely say, unless you can see the metastases around the body, it would be quite obvious then.

CRM: And a Laparotomy is where?

Nurse: It's just a straight cut down, usually if it's for abdominal obstruction they will by-pass if there's nothing they can do to alleviate the problem of the obstruction.

But if it's for abdominal pain sometimes there's nothing they can do, so they're just closed up and then given analgesics to keep the pain adequately controlled but there's nothing that they could actually do when they were in there. Perhaps, because the tumour was adherent to the bowel or back wall as well, so it would be too dangerous to cut it away.

There was a gentleman who went – this again was a while ago – for a gastroectomy, and he came back having had a Laparotomy and nothing else done because there was nothing that they could do for him. There was no point in dissecting his stomach – because that wouldn't have done any good. So he came back as a straight Laparotomy – it was actually on his post-op sheet – Laparotomy due to extensive metastases. So you would know then definitely that he didn't have a very good prognosis, and that would give you the hint to ask on the rounds.

In the case of the patient described in this account, clinical information is presented in the most unambiguous way, and leads to a simple conclusion: 'there was nothing that they could do for him'. What is also interesting about this account is what it suggests to us about the distribution of information about the patient between medical and nursing staff. Although the nurse is not dependent on doctors distributing medical knowledge about the potential of the patient's condition on the ward round – since this has been clearly uncovered elsewhere, she is concerned to define his future management as the object of clinical attention, to be maintained and administered, and directs her enquiries about the prognosis to this end – so defining a set of possibilities for the arrangement of nursing work.

At the moment at which a diagnosis<sup>3</sup> is confirmed and a lethal disorder identified, the patient becomes the focus of medical attention intended to forecast its trajectory and define its effects upon the body. This is a rite of passage of considerable magnitude for the patient, but one of which he or she may be only minimally aware, since the practices through which it is performed may be hidden from view and the nature and extent of the disease concealed. The effect of this confirmation is to define the patient more closely: nurses come to know in detail the dimensions and effects of a disorder, and to match the material practice of nursing work to it. Beyond this, it raises questions about the ways in which this definitive description of the state of the body can

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<sup>3</sup> Respondents tended to use the terms diagnosis and prognosis interchangeably. Clearly, there are diagnoses which have the effect of immediately defining the patient's prognosis – metastatic cancer of the liver, for example – but many diagnoses will require further work before their trajectory can be identified.

be rendered to patients, and about which patients are the appropriate subjects for disclosure.

#### 6.5. Practical dilemmas: should the patient be told?

Earlier in this chapter I indicated that accounts of the control of knowledge about diagnostic and prognostic work on the body were predicated on the apparent assumption that the patient would, at some stage, be told about the implications of her disorder. The confirmation of a diagnosis of a lethal condition presents medical staff, (whose prerogative disclosure is), and nursing staff (who occupy a peripheral position in the decision making process), with a set of practical dilemmas about its provision to patients. Although nurses characterised themselves as marginal actors in decision making about disclosure, there was a general preference for open and honest disclosure to the patient.

Nurse: I am very much of the opinion and I think the charge nurse is too, that as long as there are no untoward factors, I would sooner people knew.

However, despite this general preference respondents' accounts were organised around the assumption that there were some patients for whom there were good reasons not to disclose prognoses directly. The accounts contain an informal set of criteria that underpin this assumption and which revolve around the patient's capacity to 'cope' with disclosure.

The first of these is related to the capacity of patients to retain information about their condition if it was given to them:

Nurse: You know, if they've short term memory loss you've had it because *every day* you're giving them this new bombshell that they're terminally ill. These are the sort of patients that I don't think I would tell.

The repetition of disclosure demanded by this type of condition was seen as



highly stressful not simply for the patient, but for all participants. The perceived needs of relatives were given great weight by nurses, especially with regard to the second 'type' of patient for which there was a bias against open disclosure, the very elderly. Confused or demented elderly patients were seen as problematic because of doubts about their capacity to comprehend information provided to them about their condition. As a consequence, it was most unlikely that such patients would be advised of their prognosis.

CRM: Some patients actually might not be told, for various reasons. How do you deal with that?

Nurse: I'm trying to remember. I think I've got to go back to geriatrics to a time when I worked with patients who didn't know. And yet in that sort of situation they didn't know, but they weren't being told because they couldn't have dealt with the information anyway 'cause they weren't mentally up to it anyway, so it wasn't really a problem. I honestly don't think I've had to deal with keeping it a secret from someone who was going to ask awkward questions and put you in an awkward situation of what do you say and what do you do. It's a case of them being demented or something. They weren't going to ask you, they were in a happy little land of their own.

Although the decision to disclose lies in the hands of medical staff, nurses are actively involved in the collection of information on which that decision might be based. In the case of the very elderly, this involves incorporating relatives into the decision making process.

Nurse: I tend to see what the social circumstances are, how old he or she is, if there's a spouse. Quite often we tend to speak to sons and daughters about people who are over seventy and then decide. Obviously you do get very fit eighty year olds who are completely with you and want to know.

The role of relatives in decision making about disclosure may be highly problematic in itself, since they may have their own reasons for resisting disclosure.

Nurse: It upsets me when relatives say, 'oh don't tell my father he's not going to come out of hospital - he couldn't cope with it'. And what are they *really* saying, that *they* can't cope with the knowledge that he's not going to come out of hospital? I think it's often a fallacy that patients can't cope with the knowledge that they're going to die - I think it's a protective mechanism for the medical staff or the relatives.

While the capacity to retain or comprehend information can be demonstrated or tested in different ways, judgements about whether the patient can 'cope' or not have a quite different basis, as the nurse recognises in the following account.

CRM: Is there a general policy on the ward about what patients are told?

Nurse: I would say no. I'm not aware that there is. It's slightly different from places like Oncology where there are more ethical issues involved - my personal feeling is that every patient has the right to know what's happening to his body - and if the prognosis is poor then they need to be given the opportunity to do what they feel is the next step.

I've often heard it said that a patient wouldn't be able to cope with that kind of information - again, I think that that is wrong. Unless you can back that argument up with some psychological assessment of the patients ability to cope - and that's not something that either medically or psychologically we can pinpoint.

The lack of concrete clinical criteria over which patients should be told and the practical ethical dilemmas that disclosure involves, add to the stresses that Bennet (1979; 1987) has reported in decision making about disclosure. This is highly stressful for medical staff for a variety of reasons, and there is no doubt that in practice some doctors try to avoid it, (McIntosh, 1974). The existing literature about decision making by medical staff about disclosure is contradictory, as we saw in chapter 2: and historically there is a good deal of evidence that medical professionals have resisted open disclosure. However, because the practices which are involved in disclosure are dependent on the

decisions of a small number of senior medical staff, it is important to emphasise that there is also a good deal of variation in practice between individual consultants, and also because of the mobility of their subordinates.

Nurse: Every six months medical policy undergoes a reversal because the senior registrar changes, and really in many ways, as I say, medical staff-wise policy comes from the senior registrar more than from the consultants because really we only see the consultants each once a week, and the registrars are there daily. So, I'd say a lot of that sort of policy decision comes from them. So it changes every six months. But generally as nursing staff we feel patients should be told, and talked about, and actually they are on the whole, and someone talks to them.

Irrespective of the actual practices employed by specific consultants and registrars, some respondents questioned the right of doctors to make such an important decision without consulting nursing staff.

Nurse: Well, first of all there's the controversy about telling the patient his diagnosis, which I have very mixed feelings on. Ethically I suppose they are entitled to know what's happening to them. But quite often, one of the consultants particularly, he makes the decision whether the patient knows or not, which upsets me because I feel they're only the consultant, they're not God.

And they *cannot* make the decision. Different individuals will react very differently to being given the diagnosis. Obviously, if relatives are very close to a patient, and advise not telling I think that needs to be seen to be very carefully considered. However, medical staff *never* approach nursing staff and ask what we would like them to be told, or you know, should they be told. There's no discussion at all.

The decision not to disclose renders interactions between nurses and patients highly stressful and parallels the uncertainty that exists prior to the confirmation of diagnoses. In cases of 'closed' awareness, the appropriate

response to patients who articulate suspicions or alarm about their condition is always uncertain, and since disclosure is not within the nurse's remit responses must be negotiated with medical staff.

- CRM: Some patients don't get told, do they?
- Nurse: No. Some very elderly people it wouldn't be - I don't think - very beneficial to tell them. But usually, relatives are told.
- CRM: What kinds of problems does that give you?
- Nurse: You're just very fearful, in case they ask something. You don't want to say 'I'll go and ask the doctor' as if you're shrugging it off. You do have to answer as honestly as you can. It's very hard at times, obviously, you don't want to say too much because then you're going above the medical staff. You tend to consult with them first and find out what you can say.

As the extract above shows, non-disclosure also has the effect of diminishing the nurse's field of discretion to manage the patient by rendering the limits of that discretion dependent on the advice of medical staff.

One of the most interesting features of nurses' accounts of decision making about disclosure was the apparent absence of explicit policies about how it should be conducted, even in areas of relatively high mortality. All respondents were asked if there was a general policy about disclosure on the ward on which they worked, and while all answered in the negative discussion about disclosure policies frequently involved an appeal by respondents to the individual characteristics of each case. However, like Gray (1977) I found it difficult to locate specific *individual* characteristics against a general set of 'types' oriented around age, intellectual competence, neurological disease or deficit, and relatives' attitudes. It seems to be the case that patients who were elderly and whose next of kin resisted the prospect of disclosure were least likely to be told, while relatively young patients were disclosed to more often. One group of patients were almost certain to be told: doctors, pharmacists, and nurses. It would be very difficult to conceal the nature of their disorders from this group given their familiarity with symptoms and procedures. In only one area from which respondents were drawn was there a suggestion that all those

who could be disclosed to were, and this was explained on the basis of the danger to the patient of some of the surgical interventions undertaken there.

Nurse: They are told the pros and cons every step of the way – that's one thing I can say for them. The consultants take so much time with each individual, they go through it from beginning to end.

The nursing work involved in decision making about disclosure was characterised by respondents – where they were involved – in terms of the collection and collation of knowledge about the patient which might be useful to medical staff as a basis for decision making. For respondents, the preference in favour of disclosure was related closely to the magnitude of problems associated with *non-disclosure*. As one nurse pointed out: 'once folk know what's wrong they *are* much easier to deal with'.

Precisely how, and to whom, diagnoses and prognoses were communicated by medical staff remains problematic. Clearly, the question of disclosure is underwritten by important ethical considerations: as respondents make clear, there is the question of whether the patient has a *right* to know and the influence of other actors on medical staff in the events in which these decisions are made. It is important to note here that although nurses are apparently marginalised in the course of these events, their emphatic demand to be included in them can be seen to be founded on the position which I outlined earlier in the chapter, that they may know the extent to which (a) the patient is already aware of his or her situation; and (b) the extent to which the patient has expressed – implicitly or explicitly – a desire to know about this. Nurses are advocating a number of connected issues here: the patient has the *right* to disclosure; relatives should have no right to prevent disclosure; and medical staff should not make disclosure without first consulting those nurses or relatives who *know* the patient.

For the nurse who has been faced with direct questions from a patient during the period in which a diagnosis and prognosis have been established, and who is then confronted, perhaps, by relatives who wish to restrain disclosure, and who may also be uncertain about the way in which the registrar or consultant intends to deal with this, the situation raises a number of dilemmas. On the



threshold of disclosure the nurse is coming to know the patient not just as an actor dislocated by incorporation into the practices of the hospital – or by the trajectory of a lethal disease – but also as the centre of a set of potentially conflicting set of decisions about disclosure which may not coincide with the nurse's own position.<sup>4</sup>

#### **6.6. Uncertain work: nurses and the threshold of disclosure**

The period in which diagnoses and prognoses are established is rendered problematic for the patient, nurses and medical staff by uncertainty about the precise nature and possible trajectory of the disordered body. The form which diagnostic practice takes makes much of this uncertainty inevitable, and my objective in this chapter has been to explore some of the ways in which nurses are involved in its management, and the part that they play in promoting or inhibiting the patient's awareness of his or her condition during this period.

At the outset, I want to draw attention to two distinctive levels or spheres of uncertainty in which nursing work is undertaken at this stage in the patient's career, and which the nurse has to negotiate. First, at the point of encounter with patients and their relatives nurses are exposed to patients' attempts to possess that information about them which has already been generated. Again, this is unavoidable: nurses constitute the 'first line' of contact between the patient and the institution in which he or she is contained, because of their frequent contact and close proximity. While there are significant structural inequalities of power between nurses and patients – and although these may be undermined to some extent by the implicit contract of trust and personal sympathy which underwrites patient care – these are relatively less significant than those which exist between patient and medical staff. The consequence of this is that patients' attempts to press the nurse into providing information may be delayed or defused by a set of techniques which rely on the structural inequality of knowledge and power between medical and nursing staff – and which make it clear that nurses are not empowered to communicate diagnostic

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<sup>4</sup>It is important to emphasise that this 'knowledge' is always provisional and never complete: the discontinuity of nurse-patient relationships, the clinical trajectory of the patient, and a number of other factors – notably the extent to which the patient is willing to talk about herself – will inhibit its collection and collation.



information – even when the nurse is fairly confident about the diagnosis and the possible effects of the patient's disease.

While the motive for mobilising these techniques can be seen to be ambiguous,<sup>5</sup> I remain uncertain about the extent to which it is possible to challenge deflection and reflection on these grounds at a more general level. Although there is a great deal of literature which seems to suggest that avoidance behaviour and the evasion of 'awkward questions' is a problem in some nursing environments I would argue that these are attended by a specific set of conditions,<sup>6</sup> and it is to these that I now wish to turn.

At this relatively uncertain stage in the career of the patient, nurses are under considerable moral pressure not to disclose more than the most basic information to the patient, and to leave to medical staff the work of announcing diagnoses. The mediation of uncertainty is an important element of power relations between professionals and their patients: as Davis (1960) has pointed out, 'functional' uncertainty is deployed by doctors as a means of controlling both the outcome of specific interactions and as a way of structuring the patient's expectations of tests and treatments, and Melia (1981) has extended this analysis to an examination of relations between student and staff nurses. In this case, we can see how nurses are compelled to employ functional uncertainty to maintain their relations with both patients and doctors. Hence, nurses employ tactics which meet that demand but which may be highly stressful: undermining the 'trust' relationship between nurse and patient by deflection; or *implicitly* disclosing the possibility of a particular trajectory through reflection. However, underpinning these techniques through which nurses respond to the demands of patients and relatives, is their own uncertainty about whether and when this information will be disclosed explicitly by medical staff. As diagnostic evidence is accumulated nurses are progressively marginalised in the practices through which decisions about disclosure are made and enacted.

Like nurses in other studies – Field (1984) being a case in point – respondents

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<sup>5</sup>As one respondent whose account is given in this chapter recognises quite explicitly.

<sup>6</sup>See, for example, my discussion of Knight and Field (1981) in chapter 2.

expressed a strong commitment to a more open and honest provision of information to the patient about his or her condition.<sup>7</sup> While an element of idealisation may underwrite this, there is good evidence that informed patients are less problematic in terms of their clinical management (Raiman, 1988), and there seemed to be no doubt among respondents in this study that patients in possession of information about their condition were 'easier' to manage and asked fewer 'awkward' questions. More importantly, and I think that this somewhat undercuts the possibility of idealisation or evasion, is the emphatic *political* demand for inclusion in the decision making process about disclosure which runs through nurses' accounts of their work at this stage. This lack of inclusion clearly separates the respondents in this study from those described by Field. In this context, the gate-keeping techniques employed by nurses can be seen to be the direct effect of the very limited field of discretion in which they operate prior to disclosure. Not only are patients and relatives uncertain about the nature of the disorder, (as nurses may be initially), but nurses are themselves uncertain about the extent to which they will be involved in – or know about – medical decision making about disclosure. At issue here, as Moloney (1986) points out, are policy decisions made by a small number of powerful actors within the medical staff. Additionally, the continuity of personal relationships between nursing and medical staff is disrupted by the biannual turnover of senior registrars, and the more fragmented, although relatively rapid, turnover of nursing staff that I noted in chapter 4.

Nurses' exposition of their 'uncertain' work with the pre-disclosure patient opens up the question of the sources of its problematic qualities. This work is *about* patients, but is remote from them – oriented as it is around the potential for restricting their access to medical knowledge. The practical dilemmas which permeate nurses' encounters with patients at this stage in their careers have their source elsewhere, in the ordering of powers between medical and nursing staff and in the ways in which these are represented in the organisation of nursing work. It is quite clear in the accounts reviewed in this chapter, and in the emphatic demand for inclusion which underpins them, that what is being negotiated here is not just the problematic patient but the problematic *doctor*.

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<sup>7</sup>Of course, this needs to be qualified: since judgements about whether or not the patient would be able to comprehend this information, and more ambiguous notions of whether disclosure would be 'beneficial' were consistently brought into play.

Therefore, the need to be 'diplomatic' is a feature of operating in a *set* of power relations rather than a response to a particular dyadic encounter. In consequence, we might see reflection not simply as a response to a particular encounter with the patient, but also as a response which subverts the more general set of relations in which individual nurses are located, in that it undercuts the absolute authority of medical staff.

The second point that I would wish to make here involves the question of surveillance that I introduced in the concluding discussion to chapter 5. If, as Armstrong (1983b) and Arney and Bergen (1984) have argued, monitoring or surveillance of the patient as a subject has become the mode through which medical control over the individual is exercised; and if, as I have argued, nurses are best placed to perform this on the ward – how is surveillance to be exercised at this moment of constraint?

Clearly, the monitoring and dissection of the body continues without interruption and it is through this that the patient's status is defined and consolidated. However, there is an interruption or hiatus in the exercise of the nurse's therapeutic gaze at this stage or moment in the patient's trajectory. We can see this in the way in which gate-keeping is undertaken not just to mediate between patient and doctor, but to sustain a social distance between them. In this sense, gate-keeping is a response to the outcomes of what Bloor and McIntosh (1990:164) have called 'surveillance by proxy' or 'self-reporting'. The patient reports not only pain, but a desire to know its implications. The nurse recognises this but is not permitted to act. It is at precisely this moment that the nurse's discretion to act is at its most limited, since decisions about disclosure are the prerogative of medical staff. The important point here is that as a strategy of power, surveillance depends on the capacity to act to include, rather than exclude, as Arney and Bergen (1984) have noted. The power to include the patient among those who *know* lies with the doctor, and the only way in which (at this stage) it is possible for the nurse to undertake this is to affirm – however covertly – the patient's self-report. Underpinning the contest over inclusion in decision making about disclosure, then, is the question of the value of surveillance if medical staff are reluctant to take on what has become 'known' about the patient through it.

In this chapter we have seen how contest over nurses' inclusion in medical decision making about the disclosure of terminal prognoses to the patient

undermines nursing work directed at coming to know him or her as a social actor. The politics of inclusion and exclusion remain vital, however, and in the following chapter I examine its effects in the period in which the patient is made aware of the form and implications of his or her disorder.

CHAPTER 7  
'HELPING THEM THROUGH IT':  
NURSING WORK, DISCLOSURE, AND ITS  
CONSEQUENCES

### 7.1. Introduction

So far, I have drawn attention to the importance that respondents attached to 'knowing' patients – both as objects of clinical attention, and as active subjects implicated in a set of social relationships – and to the ways in which the routines through which medical decisions about disclosure are made restrain the practical deployment of this 'knowledge'. In this chapter, I focus on that period of the patient's career in which a terminal prognosis is disclosed, and explore the ways in which the nurse's field of labour expands to include work which directly addresses the consequences of this medical decision and its activation.

The disclosure of a terminal prognosis by medical staff is the formal evocation of the patient's organic crisis. It signals a substantive shift in his status as a social actor and as the object of clinical attention. For the patient, disclosure actualises a traumatic crisis,<sup>1</sup> that – as Elias (1985) has observed – emphasises and confirms separation and isolation from others, and forces a confrontation with their disengagement from the world. Clearly, disclosure involves other actors – both intimate and remote – in contact and confrontation with this crisis, and the drama and trauma consequent on disclosure may be acute problems for both medical staff and nurses. As a result, the act of disclosure is organised around the inversion of the 'rules' on which the maintainance of their previous uncertainty was founded. Where relations between the patient and staff were conducted in the public arena of the ward, they are now organised in ways which conceal and privatise the patient's engagement with a set of *certain* predictions about his or her body and its trajectory. This

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<sup>1</sup>The extent to which this is a crisis for patients, or whether it could be better characterised as a 'life event' or 'rite of passage' is an important problem. This is dependent, of course, on the individual character of the patient. For some it will be a crisis of great magnitude, and for others less so.

privatised encounter is the initiating point for work directed at managing the patient's disengagement with the world.

## 7.2. Disclosure and interpretation

Nurses' accounts of their activities during disclosure revolve around their relations with medical staff: and although the presence of a nurse at disclosure may be regarded as desirable, (Charles-Edwards, 1983), to ensure that the patient is accompanied by a familiar and sympathetic figure during a traumatic moment in his or her career, this feature of nursing work is entirely absent from respondents' descriptions. However, nurses insisted that it was vital that a member of nursing staff was present during disclosure on the grounds that they need to be certain that they have a precise account of the information that has been given to the patient.

CRM: Then, presuming that the patient is well enough to be told, 'cause I know some won't be - what would happen?

Nurse: The next of kin, and the doctor and nurse would go and speak to them. That would take place in a quiet room - quite often that person may already be in a single room - we'd make sure of that. And the patient would be told, obviously to their level of understanding. And we would know what was said, so we wouldn't be contradicting the doctor - and we also document quite strictly on the notes who was there and what was said.

The demand for precision in this account focuses not only on the power of medical staff to define the trajectory of the disorder authoritatively, but also on the importance of the patient having a single account of the nature of his illness. Contradicting the doctor not only subverts orderly relations between nurses and medical staff but may also confuse the patient. The location of the disclosure 'interview' underlines its special nature, and typically - though not always - this is undertaken in private.

Nurse: They're always told in private, but if they're in a four bedded male room we've no option but to



keep them there, then they'll be taken through to the relatives' room<sup>2</sup> - which gives the doctor and nurse a chance to speak to the patient and gives the patient a chance to ask questions.

Practices are highly variable, however.

Nurse:

One consultant always tells them, regardless. It doesn't matter whether the patient is confused at this point and quite often they have brain metastases and are very confused - and maybe they don't understand what they've been told anyway - but he will still tell them. He generally tends to tell them either when he has all the medical staff with him, or he just goes in on his own: and he never tells anyone, and I find that very hard to cope with. The other one will discuss it with the rest of the medical staff, and sometimes will not tell, sometimes tell them and sometimes hold off for four weeks and then tell them. He sort of tends to gauge it slightly more, but he doesn't ask the relevant people, which irritates me, and he doesn't speak to relatives.

Again, this extract raises the issue of nurses' incorporation into the interactions in which disclosure is made. While disclosure is undertaken by medical staff, nurses are the practical managers of its consequences and need to have a full account of what has been said to the patient, since the patient, (and relatives), may be unreliable witnesses, having 'lost' or misunderstood the doctor's words in the initial shock of the encounter. In the period after disclosure, nurses may need to mobilise this information and activate a set of practices that respond to patients' need to understand their disorder without contradicting the information given to them by medical staff, or undermining their authority. In the period immediately around disclosure nursing work with the terminal patient devolves on the interpretation and mediation of medical information. Because much of this work is predicated on what patients have been told, and how they have reacted to the traumatic revelation of their crisis, the exclusion of nurses from the act of disclosure may be highly disruptive.

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<sup>2</sup>A small bedroom off the ward which is available to relatives who need to stay in the hospital overnight.

Nurse:

We like a member of nursing staff to be present, and that doesn't always happen. I've been left in an *extremely awkward* situation - when the medical person actually went in and told the man - no, tell a lie - he told the wife first, in the relatives' room *without letting me know they were in there*. While I was in comforting the wife - because obviously this was drastic news, he only had a couple of days left to live, *he went in and told the patient without me there either*.

And I spent the next half hour running between the two, because neither of them could talk to each other, because they were scared of what the other would think, and then eventually you get them together and everything's all right. I was still in a position where you were fishing for information about what the doctor actually said, because he left without telling me.

This vivid description of a catastrophic failure in communications between medical and nursing staff points to the ways in which a whole set of relationships collapse in the aftermath of an abrupt, and perhaps ill-considered, disclosure. The traumatic consequences of this disruption of human relationships in the most extreme way undermined not only the relationship between nurse and patient, but also between nurse and doctor, and this led to a good deal of ill feeling between nursing and medical staff in this unit. The problems that this kind of event generate for nurses in their interactions with patients are echoed in a less extreme incident reported by another respondent.

Nurse:

You have to gauge it - how you deal with them - very much on the individual and really it depends on how much they've been told, you know? Or, *if* you've been told that they know. Sometimes it's quite by chance, sometimes you're asking about something quite different - you'll be asking the doctor if the patient can go home and he'll say, 'oh God he can't, he's been told his diagnosis. It really is quite hairy when you find out!

Recently we had a lady who has a very poor prognosis, a single lady in her seventies - very bright and cheery - who was told, and the first I knew of it was when she told me. She said, 'by the way nurse I've just been told I'm dying'. And I said, '*are you?*' Now I knew that they were carrying out tests, but I didn't know the results and I certainly

didn't know she'd been told.

That's the big problem - quite often it's done on doctor's rounds and there's not a nurse there so you've no idea of what's been said to the patient, you've no idea of how much hope they've been given or whether they've been given none - or even about the way that the doctor spoke to them.

These incidents emphasise the importance of the nurse having access to detailed information about the form that disclosure has taken either through being present herself, or having a detailed report from another member of nursing staff. The failure of medical staff to include nurses in disclosure is highly problematic in some cases, but as we saw in chapter 5, the distribution of nursing staff throughout the ward can also generate problems in the sharing of information about specific patients among nurses. Hence, there was a general preference among respondents to be present themselves, although as we have seen in the accounts presented so far, this is in the gift of medical staff.

Nurse: We usually get to find out, but I would sooner be there because its easier to pick up the pieces afterwards if you know exactly what's been said, and how the patient's reacted.

CRM: And some people may have difficulty understanding what the doctor has said to them in the first place.

Nurse: Very much so. I think it's to do with how long the doctor's been in with them for - if they've been talking for about twenty minutes you can be sure that they would only have taken in the first three minutes of the conversation.

'Picking up the pieces' involves not only dealing with the initial shock of disclosure, but also responding to the inevitable 'awkward questions' which follow. At this stage, the nurse is involved in interpreting medical information to the patient.

CRM: Is a member of nursing staff present when they are told?

- Nurse: Yes, always. So then you know at least how much they know, and we may want to reinforce it later – what the doctor has said.
- CRM: Because sometimes they don't take it in do they?
- Nurse: Oh no – no way that they can – *it just hits them*. They always come back later in the day and say, 'well, what did he say about that'. It's quite good that way, and then we arrange to speak to the relatives as well, it reinforces it from that point of view.

'Not taking it in', can be a major problem, and for this reason it is important that nurses are aware of the limits of patients' comprehension of their condition.

- Nurse: You'll find that the doctor'll go in and tell them what's happened and what's going to happen, and they don't usually take it in the first time – or maybe the second time, third or fourth time. You've got to be there for the questions afterwards – because if they've not taken it in, or if they don't understand what the doctor's been saying, and if they don't want to ask any questions [at the disclosure session] – you usually find that they'll come to a nurse.

When the patient does approach a nurse, his questions can be extremely problematic, given the uncertainty that may surround the trajectory of a final illness.

- CRM: I imagine that you get some awkward questions.
- Nurse: It depends on the patient, you know, some of them are really matter of fact about it and easy to talk to, and will say something like 'will I die?' And depending on the person you can really say, yes – but it might be some time. Others, you have to, I don't know, talk them round to things a bit easier so that they understand that it's not going to be instantaneous. It's quite hard though, and not many come straight out and say 'am I dying?' really.

In interpreting the information imparted to the patient at disclosure the nurse is involved in more than the explanation of unfamiliar clinical terms. Interpretation may involve the reconstruction of the physician's account in a form that is directly accessible to the patient and relatives. Clearly, this can only be effectively undertaken if the nurse has had access to the information delivered to the patient him or herself, hence respondents' insistence on the presence of a member of nursing staff at disclosure. In the preceding accounts, the traumatic shock to the patient that is inherent in disclosure is seen as a key element from which the need for further explanation and interpretation springs, as the following incident makes clear.

Nurse: I remember going in and spending half an hour with a lady we had on the ward because of the way that the doctor spoke to her. The only word that she remembered from the whole conversation was 'cancer'. Now - what he'd actually said to her was - 'you don't have cancer'. But it was the only word that she remembered, and she was convinced that *this was it* and she was going to die. It really took a long time to convince her that I was actually right, and I went and got the doctor to come and speak to her again just to make sure that she understood. She had just focused on the word cancer and she didn't take anything else in. The doctor went away under the impression that everything was hunky-dory, he had told her it was a benign tumour.

While this incident is rendered problematic by what the patient 'knows' about cancer and its potential effects, it is also rooted in the failure of the doctor to ascertain that the patient actually understood what she had been saying. Of course, the patient's lack of knowledge about the body may be equally problematic for the nurse.

Nurse: I think it depends on how much understanding they [patients] have got, and how much they want to know. Some patients are quite accepting of what they're told and won't question the doctor. We query whether they understand, but I'm quite often sure that they don't, and I'm sure that half the relatives don't have a clue what the problem is. We've got a man at the moment who didn't even know he had a spinal cord. I know not everyone

does, but after many explanations that man still doesn't know what's been done to him and neither does his wife.

Disclosure has effects, of course, beyond the explication of clinical details about the pathology of the body: it defines a shift in the social status of the patient, and in the aftermath of disclosure this is exposed in the public arena of relatives and friends. Beyond the trajectory of the body which is defined through disclosure, the nurse is open to questions about what this means for the patient as a human subject. The importance of interpretation lies in the way in which it forms the point at which nurses begin to respond to this crisis of the subject, through mobilising not just knowledge about the body, but also what they 'know' about the patient as a social actor.

### **7.3. Social spaces and the privatisation of terminal care**

The removal of the patient from the public arena of the ward for disclosure reflects the sudden shift in status which the patient experiences: while gate-keeping strategies operate on the basis of the control of medical knowledge in the public arena of multiple occupancy bays, disclosure demands its release in relatively private surroundings, so the shift to being defined as a *terminal* patient signals a gradual withdrawal from the public life of the ward. All respondents emphasised the importance of moving the patient into a single room where this was possible, through an appeal to two moral imperatives: ensuring 'peace and quiet' for the patient; and ensuring private interactions between the patient and relatives. But this resituation of the patient operates beyond the instrumental, since the social definition of specific spaces defines the character of the occupant. The general category of 'terminal' patients cuts across the boundaries of clinical specialisation, and emphasises the 'otherness' of its inhabitants. This is a process which begins in the construction of spaces in which interpretation and explanation are undertaken.

While the creation of appropriate environments for nursing work were regarded as highly important by respondents, for the most part they were concerned to appeal to the benefits that privatisation involved for the patient. Once relocated in a single room the patient's visiting rights are radically expanded.



Nurse: We also allow visiting as appropriate. We have visiting hours but they're not set ones, we look at the time of day and what's been happening to the patient – we allow phone calls, let them speak to relatives – anything that'll help with the anxiety.

However, while the privatisation of patient-relative relations is privileged in these accounts, it is underwritten by the potentially disturbing and disruptive effects of the 'terminal' patient in the public areas of the ward. This is brought very clearly into the foreground in the following account.

Nurse: What we usually try and do is if a patient is terminally ill we try to get them into a side room, it's more private there for them and their relatives. There's nothing worse, I think, than being with relatives and other people listening, it must be awful. That's a really private time for people and we usually say to relatives that they can come and see them any time they want – it doesn't matter what time of day or night it is – if it's a wife or husband, or especially children, then they can go and stay in the relatives room in the ward.

It *depends* though. Post-op patients go to the end room, which is four bedded, and if they go in there and die it's unfortunate. The other night one just sat up, looked at me, and then died. It happened in seconds, there was no way I could envisage that. But luckily, the other man in the room wasn't really *compus mentis*, so he didn't really know what was going on. I think if you *know* someone's deteriorating, and you know this is going to continue, then they need to be moved to a single room.

CRM: I can imagine that the kind of event you're talking about can have serious consequences for other patients – in terms of morale.

Nurse: Yes, definitely. I think it would be *appalling* if you're in a four bedded room and someone dies, especially if you're waiting for surgery.

Presenting this move to the patient requires great care.

Nurse: I suggested it might be easier if his wife and him wanted to talk if they were in a single room anyway. So that gave me an opening to say, 'we'll move you through'. Rather than him thinking that he was going into a single room because he was

deteriorating. I sort of suggested it might be nice because they could have a chat together and they would have more privacy. He was only young, he'd had an operation and gone home, but then he had a relapse and there was nothing we could do.

While privacy for patients and relatives is regarded as vital, the single room also provides the nurse with a space in which nursing *work* may be undertaken without disruption.

CRM: You were talking about privacy just now, is that a problem?

Nurse: Oh yes, it is. This is where having the single rooms is really quite nice, because our single rooms have their own toilet and shower, like a private room,<sup>3</sup> right?

This particular lady we had in, she was going to be here for another couple of weeks waiting to go to the hospice, so she stays here and we just moved her into a single room. Relatives were coming to see her whenever they wanted, and the room gave her privacy for that, and when you were in there with her with the door shut, nobody bothered you. *It was great.*

Quite a lot of the staff think that screening off the patient gives them privacy. It gives them privacy from being viewed, but it doesn't give them any privacy for talking or whatever. It's sort of cutting the line, *your space* but it doesn't work at all. But these side rooms are super, inasmuch as if someone's terminally ill, and we lose a fair number on this ward, you tend to get moved very quickly from the six bedded room and put in a side room if their condition deteriorates. Hopefully - well partly for peace and quiet - but mainly for the relatives to come in.

This respondent makes the important distinction between the symbolic privacy of drawn curtains - behind which events may be guessed at or overheard by

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<sup>3</sup>ie. a pay bed

other patients and staff – and the concrete privacy provided by the single room. However, if single or 'side' rooms are not available, there are a range of other spaces in the ward where doctors, nurses, patients and relatives can discuss the implications of a patient's disease.

Nurse:

I think sometimes it's the questions – often the same questions – that need to be clarified. And I think it's just the *time* that you can spend with them. We're usually staffed enough that the nurse can leave the ward to do so on a one to one basis, or you know, to go over information – just to spend time – and not to be talking to them out on the corridor in a busy ward and be called away to the telephone.

To actually be in an environment where you can stay there and know that the ward is OK, and that you don't have to worry about it. It's quite good. We don't use the duty room, we use the coffee room, or somewhere that we know we won't be disturbed. And I think it's just the fact that the nurse can actually spend time and sit down with a patient – and the doctors if they are asked to come back again to re-explain, they will. They're quite good about that, even if there's nothing more that they can say, they'll go back over things. I think the best thing you can do with somebody who is dying – is just to explain their care and things that are going on simply.

Time is a vital resource for nurses in these situations, but for the nurse to be able to spend time with patients demands a level of staff allocation on the ward sufficient to ensure that this does not disrupt other activities. The seclusion of the patient in a private space plays an important part here, by freeing the nurse from other – more immediate – demands.

Nurse:

You know, in the six bedded ward you're talking to somebody *and* watching one of the geriatrics stotting off down the ward – and you can't possibly leave this conversation and go rushing off after the other one – so it is hard.

The privatisation or seclusion of terminally ill or dying patients from the public

arena of the ward creates opportunities for the nurse to respond to private needs and crises. The private experience of 'talking to patients', and 'spending time' with them are key elements of nurses' accounts of their work with the terminally ill and dying, but it is important to emphasise that this does not mean that organic disorders and their effects become a secondary issue. On the contrary, nursing work directed at the body becomes increasingly important to ensure the patient's comfort – for example, through the administration of pain relief or the treatment of pressure areas. However, the changing status of the patient, evoked through the act of disclosure and a subsequent transfer into secluded or private spaces, is paralleled by a shift in the direction of nursing work towards the inorganic. I want to turn now to the ways in which this shift is constituted, and its effects on the arrangement of nursing work.

#### **7.4. 'It is hard talking to them': working with the terminal patient**

So far, I have been concerned with the ways in which the nurse-patient relationship pivots on work connected with the administration of knowledge about the body. But in the period after disclosure, apparently ambiguous notions of 'talking' and 'spending time' with patients become a central focus of nurses' accounts of their work. It is important to emphasise that these terms refer to actions which respondents perceived as purposive areas of nursing work that were highly problematic. For obvious reasons, the patient who has recently been told that his or her condition is lethal may be anxious, depressed or agitated; and respondents stressed the potential for interventions which helped patients to respond to their new circumstances.

Nurse:

I think that one of the first things that we have to get over to them is that we can make sure that they're pain free, because that's one of the things that they get worried about. Another thing is getting over the fear that's involved, because dying is a very fearful thing. Dying alone and dying in fear are the two things that people fear the most. So I think you have to be open with the patient, and you *cannot* be seen to be avoiding them just because it's a difficult thing to tackle. It's our responsibility to make sure that the patient gets all the comfort that they need. They have to know that if there's something that they want, we will organise it for them and that all the stops will be pulled out.

Whether these prescriptive demands can be met in practice may be problematic, but at the root of work which is intended to meet them are notions of 'knowing' the patient. At this stage in the discussion I want to employ a more expansive definition of the term observation, which - so far - has been restricted to describe nursing work which addresses the condition of the body and the extent, and trajectory, of its disorders. Much of this work is routine and involves, for example, the visual inspection of wounds and lesions, or the measurement of temperature and urine output. Clearly, work which is directed at the collection of information about the body is a relatively constant feature of interactions between nurses and patients - and its legitimacy is very rarely questioned by the patient - whose presence on the ward is defined by the necessity for observation and treatment of the body. In this context, nurses' enquiries about how the patient 'feels' are relatively unproblematic. They refer specifically to the body and are undertaken against the background of a mass of 'scientific' medical knowledge about 'normal' and 'abnormal' pathology. The application of this knowledge through the interpretation of signs and symptoms, and through interventions which relieve and maintain the body, was seen by respondents as unambiguously nursing work.

While for most patients the experience of this work is directly connected to their restoration to health, the 'terminal' patient has no such potential, and surveillance of her responses to this state is undertaken through 'talk'. Underpinning respondents' accounts is the notion that this 'talk' - through which the patient is revealed *in depth* - is entirely legitimate, and that most patients will wish to do so and find it helpful. While 'talk' is stressed in nurses' accounts, it is important to note that this surveillance of the patient's social and emotional condition involves visual indicators of behaviour as well as verbal exchanges. Nurses 'know' the patient by how they 'look' as well as by what they say. These observations are constituted through enquiries about the patient's social and emotional - rather than organic - state, and have a different basis to those made about the state of the body. Knowledge about the body is organised around apparently objective benchmarks - the difference, for example, between a 'normal' and 'abnormal' body temperature - but these are more difficult to come by in the observation of the patient as a 'normal' human subject. It must be noted at this point that there is, of course, a body of medical knowledge which defines, (and attempts to explain), behavioural disturbance and mental illness: however, I did not encounter in the course of the fieldwork, nor have I seen any evidence in the literature to suggest that

this is routinely applied by nurses in general hospitals to patients who are terminally ill.<sup>4</sup> Ambiguity about what particular behaviours may mean is compounded by the problem of establishing what normal behaviour *is* for an actor dislocated from a 'normal' environment. Moreover, while enquiries about the body may be viewed as entirely legitimate by the patient, enquiries directed at how the patient 'feels' about her disorder and what it means to her, may not be considered legitimate.

Nurse:

I think once the patient has been told about their prognosis the atmosphere thereafter can be very difficult, because they're not sure whether you know what's going on or whether you want to talk about it. You can put out all sorts of cues to them if you want to, but if they don't respond then that can be difficult. You feel that the patient doesn't want to talk about it, or that they don't want to talk to *you* about it. That can be hard.

In this account the respondent is concerned to emphasise the uncertainty which underlies the relations with patients at this stage in their career. While the legitimacy of 'talk' between the nurse and patient about how the patient 'feels' has to be negotiated and established by mutual agreement, this may be difficult if the nurse (or *a* nurse) has not been present at disclosure.

Nurse:

Some people just don't want to talk about it afterwards; some people will just talk to you for hours. You just don't know. But if you were there, then at least they know you know. Sometimes I think that when medical staff go to speak to them about it some patients are under the impression that we don't know what's wrong with them. And perhaps they don't speak to us because they don't want to, they'd rather discuss it with family, or else they're under the impression that we really don't know what's wrong with them or what was said by medical staff, so they just don't say anything.

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<sup>4</sup>What are applied are 'types' or categories of patient - 'accepting', 'withdrawn' or 'angry' which relate to their behaviour post-disclosure. These are largely derived from work which attempts to define the stages of terminal careers, notably from the work of Elizabeth Kubler-Ross (1970).



Uncertainty about whether the patient wishes to 'talk', and understands that it is legitimate to do so may be oriented around patients' assumptions about what nurses 'do' and what they 'know' about their condition. Clearly, if the nurse is present at disclosure these assumptions about the extent of nurses knowledge are undermined.

Nurse:

I think this business of the nurse sitting in [at disclosure] it's not so much that it gives us an opening, because I would never talk about it if they didn't mention it to me first. You *can* give them openings to speak if they want to, but if they don't it's fine - *but* if you were present at the interview, and they know you were present, then there's a much higher chance that they will speak to you - unless they've got an absolutely brilliant relationship with someone else<sup>5</sup> so the chances are reasonably high, just probably because you were there. It means that sometimes you don't even have to hint, they'll speak to you anyway if they want to and they don't always.

While observation of the body is a feature of the experience of nursing work over which patients have little control, observations directed at establishing their need or desire to 'talk' are dependent on their volunteering this information to the nurse. How nurses approach the patient in these circumstances is crucial.

Nurse:

If I knew someone had actually been told I would make a point about being around, and I would probably give a few open ended questions, but I would never go and sit down uninvited and just broach the subject because I just don't think that's fair.

In another instance:

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<sup>5</sup>ie. another nurse.

CRM: When somebody has been informed of their diagnosis is somebody able to spend time with them?

Nurse: We usually try and ascertain first if they actually want to speak, because some people don't want to talk about it at all. You go to them and introduce it casually and say 'has the doctor been to see you?' and 'what did he say?' Take it from there and see how they react to it rather than push it, you know, force them to say how they feel. Often they don't want to talk for maybe a couple of days, 'till it sinks in.

These accounts emphasise the extent to which the configuration of the nurse-patient relationship after disclosure is dependent on its legitimation by the patient, and that the patient has a moral right to refuse to enter into 'talk'. Of course, the patient who does want to 'talk' is unproblematic in this respect: but there may be a number of reasons why this is not forthcoming.

Nurse: For example, a patient then denies that they've been told anything, and they just carry on as if nothing has happened.

I think it's more difficult to deal with - because you don't know if you should be the one to bring up the subject to see if they want to actually talk about it or not. Usually they'll come round (in time).

The non-legitimation of 'talk' extends the period of uncertainty about what it is appropriate for nurses to do and say. In cases of concerted denial or withdrawal, the nurse has few options.

Nurse: The angry patients sometimes just don't want to know - if you say 'I've just been talking to doctor, and he says you've been given your diagnosis' (and they say) 'what diagnosis, I'm perfectly fine?' You really can't win with those patients, so again, you have to make sure that someone is going to back them up in the community. But apart from that, if they don't want to talk then really there's not the time or resources to do anything about it. But hopefully they'll be picked up by somebody else further down the line, we make very sure that the

GP would know. Quite often the patients are closer to their GP.

More importantly, the non-legitimation of 'talk' greatly reduces the potential for action on the part of the nurse. While palliative care can still be administered in respect of the organic disorder, no such care can be offered to the patient as a social actor. This is asserted emphatically in the following account.

CRM: Because people react in very different ways don't they – are there particular patient's responses that are difficult?

Nurse: I think that the patient who, colloquially speaking, turns their face to the wall is very difficult – because it doesn't give the opportunity to *do something: and nursing as a profession has to be seen to do something.*

So that can be a problem, because at the same time you instinctively know that you might be able to offer the patient some kind of help – although not a cure – to ease the pain a little bit. But they are detaching themselves from the situation and they won't let you become involved in that, and that can be difficult too – because you can't actually perceive how they feel.

That can manifest itself in two ways. Either the patient does become very withdrawn and quiet; or they carry on as normal – as if they haven't been told, they've haven't digested it, it's gone over their head, or they've chosen to ignore it.

That's very difficult because *you know*, you can appreciate what's going on medically, and you don't want to be badgering them all day and acting in such a manner that it's obvious that they're going to die, or not sending any kind of emotional reaction to it.

Similarly:

CRM So, where you've got a patient who's dying, what sort of situation do you find most difficult?

Nurse:

A patient who's quite withdrawn – they don't want to talk about it. Not about *it* but about anything at all. They withdraw into themselves and it's quite difficult to get them to accept what's going to happen to them and decide what to do.

There are occasions, however, when the patient does not 'come round' or 'accept' what is happening to them. In these cases, withdrawal is the precursor to a deeper and more tragic train of events.

Nurse:

Someone who just withdraws; who can't talk to you. Sometimes they get angry as well and that's quite hard to deal with; as well as the ones who just sort of lie back and give up – that's frustrating when you know there's no need really just to give up there and then. We had a lady like that not too long ago, and as soon as she knew her prognosis, that was it, within a couple of weeks she was dead. She'd almost willed herself to die once she'd signed her will and got her things sorted out, that was it.

Underpinning nurses' accounts of the ways in which patients resist 'talk' is an acceptance that this behaviour can be *understood* as a response to the situation which they are confronting.

Nurse:

Anger. It's only really happened to me about twice, I know that they say there are stages of dying and you will go through the anger and the denial phase and the rest of it – but really the anger phase – where it's actually being directed at me has only happened once or twice.

I think if you understand that the anger is not directed at *you* – it's to do with something else, it's easier to take. I think if I had never heard of the stages of dying, I would be beginning to probably be a bit jumpy at the way this man was shouting at me. It's a lot easier to take when you understand the reason why, you'll leave and come back another time. Maybe they'll still be angry, maybe they'll apologise for shouting at you earlier on, it just depends.

It's nice when you go back and then they're a bit

calmer and they say 'I'm sorry, I realise that I was angry, it's not directed at you'. That makes you feel better, but at the same time, if they really were angry I would prefer it if they still shouted at me - because as long as I understand the reason why - it's water off a duck's back if they shout at me or not. I'm not going to take it personally anyway.

Accounts which emphasise the voluntary nature of 'talk' - but which stress nurses' concern with establishing the conditions in which patients may undertake it - clearly involve questions of legitimation. This in turn raises questions about the kinds of 'talk' that are being legitimated, and the purposes and interests which they serve.

#### **7.5. 'Talking and listening': the shifting focus of nurses' attention**

In the period leading up to, and including, disclosure the relationship between nurse and patient is organised around work directed at the body. We have seen how this involves interactions which establish the patient's knowledge about his disorder and its effects, from gate-keeping and mediation through to the interpretation and explication of the information which is given to the patient at disclosure. After disclosure, however, the patient comes to occupy a more problematic position because of the ways in which nursing work is directed at the maintenance of the body rather than its restoration, and at social closure rather than the rehabilitation of the patient as a conscious and interactive subject. Because nurse-patient relationships are constituted through nursing work and through the modes of attention and behaviour consequent on it, this shift in attention has the effect of reconfiguring the relationship between nurse and patient.

Nurses' accounts of the ways in which their attention is directed beyond the body in their work with terminal patients are organised around 'talking and listening' and are characterised by references to availability rather than action. Patients are understandably anxious about what their terminal disorder means and its effects not only upon their own trajectory, but also on their social relations with others. In the following account a nurse describes an encounter with a young woman who had been offered surgery to alleviate the immediate effects of terminal cancer, and the issue of 'others' is brought clearly into the

foreground.

CRM: When you were talking earlier about people being afraid – what kinds of things do you think you can do to mitigate that?

Nurse: I think you've got to sit and listen to them and let them vocalise it, and let *them* talk it out – what they're frightened about – everything. I've spent time with a lady yesterday who's been given a choice of surgery. And she's very frightened because she's got two young children and this operation could affect her memory and if it does, then she'll never be able to be alone with them again. You know, she's really frightened. You know, I have no children, I can't relate to that woman. We're put in a totally unrealistic situation – what would I do? I don't know. But if she doesn't have the operation she could just stop breathing.

'Sitting and listening' requires the suspension of the elaborate set of moral pressures on the nurse to adopt a proactive role, which I have discussed in chapter 5. However, this is still *work* directly intended to assist the patient to take stock of, or to 'come to terms' with radically changing circumstances. As work it is constituted, not through the performance of material tasks and the mobilisation of technical expertise, but by *sympathetic presence*, and involves the construction of 'spaces' within work undertaken with the patient in which this presence or availability can be activated.

CRM: So where you have a patient who is coming to terms, perhaps, with the fact that they've got a serious illness that is quite possibly going to kill them, what kind of personal difference do you think that you can make in those circumstances?

Nurse: Taking time with them. I think trying to ensure that they are cared for, generally, by the same person, as far as that's possible working three shifts and 24 hours 7 days a week.

To really let them get to know one or two nurses, it's easier to talk to the one that you know, taking time over doing physical care. Often sitting a patient down and saying 'lets talk then' can be *more* frightening than anything else – talk that comes along with doing something and leads out from there – the patient asks one thing because



you're doing whatever and that leads on, and you gradually draw the patient out that way. But knowing that you don't have to say well 'sorry I can't talk now' there are others who can do the rest of the work - and just taking time - letting the patient really decide. But picking up clues.

CRM: What kinds of clues?

Nurse: When they ask that *one* question, just trying to help the patient - not just ignoring (it) - (or) getting that 'haven't got time now' - it doesn't happen very often in our place. But it's hard to always think. We've got one lady who's very quiet and she's very uptight, very anxious, but she wasn't feeling very well. And just spotting that anxiety and taking the time to sit with her.

'Taking time' with patients demands that the nurse contends with other, competing, demands of work on the ward. As we saw in the account above, however, time in which 'talk' can be undertaken can be manufactured by the re-arrangement of other work and the re-allocation of staff. The construction of 'spaces' in the routine organisation of work on the ward is emphasised below.

CRM: You were saying just now that it's sometimes not easy to find the time to sit and talk to them.

Nurse: Yes that's right, but sometimes you've got to make the time. You'll see a patient who wants to talk with you and sometimes they really *need* to talk. I think that a lot of patients will talk to us before they'll talk to a doctor, we're the first line, taking them to the loo and things like that, and they'll tell us anything first. I think it's always been like that.

The arrangement of time and space is clearly important, but it also raises the question of who is talking, and what is being spoken about.

Nurse: Sometimes if they've got a very poor prognosis then it's a case of them wondering how they're going to tell their families and what's going to happen to them, how their spouse is going to cope, if they've got children things like that. It

depends on who they are, if they've got a big family, whether they live on their own, and so on. Usually they find it a bit of a muddle at first and then everything starts to come with a rush. You've really got to sit down and work through a few points with them and then if they've had enough, come back later.

However, as the following account suggests, this kind of 'talk' may not require the nurse to take an active part in the conversation.

**Nurse:** You've got to listen. The best thing I've found is just to sit there and listen to what they've got to say. Obviously if they're waiting for an answer you try and give them one – but a lot of the questions are more like statements – they're not waiting for an answer, they're just statements.

Similarly:

**Nurse:** This occurred a few weeks ago. A person was told she had a tumour in her abdomen, but they'd only managed to take a lump out. So, I was there at the initial interview and I organised – we work as a team – for one of that team to come and see her as soon as the interview was over. She had a cup of tea and a discussion about it, and she accepted it quite well in the end, but it took a few days.

**CRM:** That must be quite difficult, just sitting with somebody and talking at times like that.

**Nurse:** Yes, it's quite difficult to know what to say – but it's usually a lot of listening involved in that. They're asking things, maybe not wanting to talk about what they've just been told but just to chat about family.

While the importance of being available to listen to patients when they wish to talk is emphasised in these accounts, it may also need to be stressed to patients. Here, a nurse describes the importance of encouraging patients to see the nurse as a figure is both available and sympathetic to their concerns.

**CRM:** Once the patient knows that their illness is terminal, and that they aren't going to recover, what's the biggest problem that you face then?

Nurse:

I think, if they're conscious and alert, just enabling them to know that their last few days or weeks or whatever - they're going to die with dignity and they're going to be pain free or whatever. Just to enable them to deal with the issues they want to deal with - with their loved ones and with their relatives: and just to know that they are being cared for and being looked after. I think that there's a fear - especially in a busy medical ward - that they're forgotten about and abandoned because there's nothing that the medical staff can do or that the nursing staff can do. And, well, that's them abandoned.

Also just to make sure that they know that people have time for them and that even though, perhaps, they see it as a fruitless task - you know, you're looking after someone who is going to die, who isn't going to go home. That in some ways is just as satisfying as looking after someone who, you know, *is* going to get better and go home. But how you convey that to someone is not always easy.

CRM:

What sort of things can you do?

Nurse:

Well, talking with them; showing them by the way you deal with them that you've got time with them, I think that's *really* important.

Not just in nursing, but, you know, just to make someone feel special and for them to know that you as an individual care about them. Whether that's just spending time talking with them, and if you've got a limited amount of time just by showing that you're prepared to give them the short time that you've got that you're concerned about them.

There's so much that we can convey by our manner and that is something that we're very bad at teaching student nurses, and perhaps because they are so wrapped up in the actual tasks of nursing - like how to change the bottom sheet of a patient - they can't sort or project themselves out of that situation, and just think, what's the message that I am conveying to this patient?

I think it's very sad when people don't want to bother nurses because they seem to be busy, and then perhaps you discover afterwards that there were things they weren't sure about, or a relative says that their husband doesn't understand - and it's something that would just take two minutes to put right. And that saddens me when things like that happen.

Accounts of 'sitting and listening' emphasise the ways in which nurses are concerned not just with palliative care for the body, but with features of the patient as an interactive subject. The account above sets these concerns out in a prescriptive form, but also locates them in the context of the pragmatic negotiation of other work on the ward. Here, the need for patients to be reassured that they will not suffer pain and that their last days will be dignified is set against the possibility that staff might avoid them because of their condition. Similarly, conveying to patients that work directed at them is seen as important and is not the 'poor relation' of more 'successful' treatments is stressed, but is contrasted with the possibility that other competing demands on the nurse might not be successfully negotiated. 'Sitting and listening' is clearly set out in these accounts as work, not as an informal or ephemeral activity connected with other tasks, but as a specific field of labour which is highly problematic.

#### **7.6. The reconfiguration of nurse-patient relationships**

The announcement of terminal prognoses present all those who take part in it with major difficulties. At the beginning of this chapter I presented several accounts of dramatic and traumatic disclosure, in which the action of medical staff departed from what respondents saw as the normal and routine order of events. The notion of routine is vital here, as Turner (1987) has argued, building on work by Sudnow (1967) and Wright (1981):

Because of the emotional and social tensions surrounding dying and death, the aim of the hospital setting is to establish a regular and routine pattern of death for large numbers of patients. (...) By establishing a social organisation of dying, these norms and practice shape the institutionalised dying process, thereby avoiding contingent and disruptive events which would threaten not only the organisation of the hospital or hospice, but of the social environment and management of the dying person. (1987:126)

This routine is initiated by medical staff in the explicit disclosure of the

patient's terminal prognosis:<sup>6</sup> however, respondents' account of disclosure revolve around the question of their inclusion or non-inclusion in the encounters at which disclosure is undertaken. We can see that the problem of inclusion operates at three distinctive but interconnected levels in these accounts.

First, it represents contest over the general arrangement of powers between medical and nursing staff and the negotiation of structural inequalities between them. Nurses assert that they are non-marginal actors and demand that their role as the mobilisers of patient care be accepted and legitimated by senior medical staff at the point at which medical knowledge about the body is imparted to patients. The variability of medical practice and the degree to which nurses are routinely incorporated into these encounters points to the ways in which this is *negotiated*, rather than structurally determined by an absolute demarcation between the two occupational groups.

Second, contest over the inclusion of nurses in decision making about disclosure can be seen to represent the negotiation of the order and routinisation of nursing work to avoid contingency and disruption. Because nurses are responsible for the care of a relatively large number of patients, as well as being involved in administrative work, the special demands of disclosure – and the arrangements that may immediately follow it – have to be located in the general arrangement of work on the ward if this is not to be disrupted. The imperative towards individualised patient care has rendered the term routinisation somewhat problematic, because of its association with 'task allocation' and deskilling. However, in the sense in which I use the term it emphasises the implicit demand in nurses' accounts for a predictable order of events on the ward. In this context, the demand for inclusion in decision making about disclosure can be seen to relate intimately to the maintenance of respondents' *certainty* about the order of their work and the arrangement of their encounters with the patient.

Finally, the demand for inclusion relates to the ways in which nurses are

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<sup>6</sup> Respondents were not empowered to undertake this on their own initiative, however, and although incidents at 'Metropolitan' and elsewhere where nurses have done so 'informally' have been described to me since I undertook the interviews on which this study is based, none of the respondents indicated that they had been involved in such an encounter.

involved in negotiating the patient's passage to open awareness of his condition and its implications over a period that extends beyond the immediate encounter in which medical staff undertake disclosure. As we have seen in this chapter, this is undertaken through a series of encounters in which medical information is conveyed and interpreted in increasingly private spaces. In this context, 'knowing how much the patient knows' is vital to the successful outcome of interpretive interactions since it enables nurses to pitch these at a level which is comprehensible to patients and relatives.

The question of inclusion is important not only because of what it reveals about substantive issues in the politics of relations between professional groups, but also because it has an impact on the formulation of nurse-patient relationships. Although this study focuses on nurses and their relationships with patients its sub-text, up to and including disclosure, has been the ways in which these are to some extent the consequences of the constraining conditions in which they are undertaken. Here, the power of medical professionals to set out the boundaries of what can be spoken about in the course of nurses' encounters with patients has an important effect on the constitution of relations between them. A respondent in the exploratory study describes this:

Nurse:

And the doctor said, 'well, you're going to have to keep her cheerful'<sup>7</sup> – and so jolly her along but we can't say too much at this stage – when we know I'll tell her'.

Discourse about inclusion, then, is directly related to the experience of being uncertain and constrained: but disclosure releases the nurse from this, and opens the patient up to a radical shift to awareness. At this moment, the configuration of the relationship between nurse and patient is itself radically changed. One way of thinking about this is to see the nurse-patient relationship as having the shape of an hourglass. This gradually narrows in the period in which investigations are carried out, and reaches its most constricted

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<sup>7</sup>Through a series of uncomfortable exploratory procedures spread out over several days.



point at the moment of disclosure, after which it gradually opens out again. In this latter period, the nurse is able to undertake new kinds of nursing work which respond to the psychosocial 'needs' of the patient who *knows*, and has a much greater degree of discretion about how this should be conducted.

It is not sufficient, however, to suggest that the release of communicative restraints on the nurse after disclosure only has the effect of opening up a new sphere of psychosocial labour. In chapter 2 I argued that the construction of the 'psychosocial' has taken the form of creating a new set of idiosyncratic symptoms which parallel the trajectory of organic disorders, and which can be 'treated' by modifying the form of encounters between health professionals and patients. The aetiology, 'symptoms' and objectives of care that are generated by this focus on the patient are problematic: and in this chapter, for example, we have seen how a number of respondents have drawn on the work of Kubler-Ross (1970) to describe discrete 'stages' – anger, denial and withdrawal – through which terminal patients pass. Although Kubler-Ross has been highly influential in setting out a theory and practice of terminal care – and as Arney and Bergen (1984) have asserted, in emphasising the importance of the dying patient *speaking* – more recently her work has been opened up to a number of substantial criticisms. Sims (1988) has pointed to the way in which these have undermined both its methodological base and practical conclusions. What I do not wish to suggest here is that the terminal patient does not experience different forms of distress, however, these may be contingent and episodic rather than discrete and sequential. More importantly, while 'sitting and listening' or 'talking' to patients clearly is seen as part of work and as purposive, it is underwritten not only by ideas about therapeutic intervention, but also by much more ambiguous notions about the nature of nurse-patient relationships. We can see this set out in the extract below.

Nurse:

To call it work somehow demeans it – I don't know whether its because I've fallen for the hype that it's a vocation or what – but you meet people at this intense period in their lives and because of that the normal social barriers and etiquette is gone. It's like you're sort of down to a deeper layer, a deeper contact which isn't just work, it's about caring for people and wanting to make a difference – I don't know, to help or heal or support – I've lost track.

While nurse-patient relationships have their constitutive basis in the performance of nursing work, in the description above this is imbued with a *moral* value and investment which undercuts its status as paid labour. The nurse asserts that the period after disclosure is in some sense 'special' and demands a particular form of attention. I have characterised the behaviour through which this attention or concern is manifested as 'sympathetic presence', but the encounters in which this is mobilised, and the configuration of the nurse-patient relationship within them, raise further problems of categorisation and explanation.

First, it is important to consider the ethical character of 'sitting and listening' and 'talking' to patients. This extends beyond the patient being the object of clinical attention or a subject manifesting psychosocial problems. Here the patient not only wishes to speak, but also to be 'known' to nurses in an intimate and private way. But while clinical attention – whether it is directed at the body or at the psychosocial – involves the nurse in actively intruding into the private space occupied by the patient, attention which responds to the patient's profound sense of social loss and isolation and to the exposition of what the experience of being a dying patient *means*, involves the patient in voluntarily revealing this. Similarly, it requires the nurse to arrange her work in a way that makes it possible for the patient to 'speak', and to be willing to participate in the encounter. Because of this mutual negotiation of the legitimacy of 'talk', and because of the ways in which the patient expresses particular emotions and tells stories about her life and about what particular figures and events mean to her, I want to suggest that these encounters take on the character of the confessional.

This leads us, in turn, to the question of the form which the relationship between nurse and patient takes within the confessional encounter. My view is that it involves the nurse in an uneasy conjuncture of roles: the underlying structural inequality of relations between them remains in place, the nurse expresses sympathetic concern while at the same time the patient reveals the most private aspects of his character: and the mobilisation and expression of sympathetic presence corresponds closely to a formal act of counselling and comfort. It retains this formality precisely because of the way in which it is underwritten by the nurse seeing particular kinds of encounter as part of work, and by the ways in which these encounters seem not to involve exchange. While the patient reveals a great deal, the interaction is not reciprocal. I think,

in this respect, the the most effective way to characterise the nurse's role – and the basis of her or his relationship with the patient – in these encounters, is to see it as *pastoral*.<sup>8</sup>

The significance of 'talking and listening' as an arena in which this moral work – 'comfort work' according to Glaser and Strauss (1965b) – is rooted in the way in which it forms the final sequence of encounters in which the patient comes to be 'known'. Equally, it is underpinned by an implicit ideal for the terminal trajectory. The announcement of an *organic* trajectory opens up the possibility of it being experienced for what it is, and of the potential for the subject to be integrated into it. It thus demands a more potent mode of surveillance and management, and it is precisely this which emerges in the accounts presented in this chapter. It is no accident that those patients typified as problematic in some way are those who cannot be integrated into the new career that disclosure announces, that is, those who are not disclosed *to*, or are those who *will* not be integrated, ie. the withdrawn and angry patients. It is these patients whose subjective experience is impenetrable to the therapeutic gaze of the nurse.

We can see how the management of the patient in the period after disclosure opens up and combines physical and social spaces in which this gaze can be activated, and which coincide with arrangements that maintain the sentimental order of the ward and militate against the disruption of work with other patients. The seclusion of the patient for the disclosure interview, (and the presence of the nurse to monitor what the patient is told about his disorder and its implications), the removal of the patient to a private space in which this new knowledge can be elaborated through the nurse's power to interpret knowledge about bodies; and the presence of the nurse in those spaces to permit the patient to render subjective responses to the experience of this new status open, all constitute a new field in which the patient can be 'known'. The patient can be both seen and *heard*, and anxieties, needs and problems announced and identified. At the same time, as Berger and Kellner (1979) have argued:

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<sup>8</sup>I do not mean by this that it has a particularly religious character, although for at least one respondent it certainly did.

Every social relationship requires objectivation, that is, a process whereby subjectively experienced meanings become objective to the individual and, in interaction with others become common property (...) The degree of objectivation will depend on the number and intensity of the social relationships that are its carriers. A relationship that consists of only two individuals called upon to sustain, by their own efforts, an ongoing social world will have to make up in intensity for the numerical poverty of the arrangement. This in turn accentuates the drama and precariousness. (1979:34)

The point that I wish to make here is that although nurses may, if we take a Foucauldian view, be agents of a disembodied discourse, through which is defined a gaze that inspects a systematically defined set of objects, ('fears', 'anxieties', and 'problems'), and while they may activate a mode of surveillance that involves strategic relations of power, we should not lose sight of the way in which they do so as *subjects* implicated in relationships with others. As subjects they may be involved in consent or resistance, or they may collude with the concealment of the subjective experience of the patient: and as Berger and Kellner remind us, the relationships through which this work is undertaken may be difficult to sustain. In the next chapter I turn my attention to respondents' accounts of the moral imperatives that underpin and inform their relationships with patients.

## CHAPTER 8

**'YOU'VE GOT TO PUT IN YOUR OWN FEELINGS':  
INVOLVEMENT, DETACHMENT AND THE BOUNDARIES OF THE  
NURSE-PATIENT RELATIONSHIP**

**8.1. Introduction**

The line that I have taken in the three preceding chapters has been to establish the contours of the nurse-patient relationship. In doing so, I have traced its changing configuration in relation to the patient's terminal trajectory. I have argued that these relationships are constituted by, and configured through, the mobilisation of particular kinds of work; and that a central feature of nursing work is the production, collation, and distribution of knowledge about the patient. Furthermore, I have pointed to the ways in which the production of this knowledge not only involves the dissection and observation of the body, but also the penetration and surveillance of the patient's subjective experience of terminal illness. Through 'talking and listening' the patient comes to be known as an idiosyncratic character, with an intimate disposition and biography.

In this chapter, I am concerned with the boundaries of the relationship between nurse and patient, and with the ways in which these are organised through moral imperatives about the conduct of work. I examine nurses' accounts of the experience of intruding into the private sphere of the subject, the extent of its problematisation, and the ways in which the perimeters of relationships are set out by ideas about the appropriate conduct of work.

**8.2. 'Being involved': ideas about the conduct of work**

Respondents' accounts of the imperatives which underpin their relationships with the terminally ill revolve around notions of 'involvement' and 'detachment'. But what nurses mean when they say that they are 'involved' with patients remains problematic. At this juncture I wish to disentangle the notion of involvement as a specific 'emotional' attachment to a particular patient, and as a *general quality* of nursing practice.



### 8.2.1. Involvement as a problem

Conventionally, nurses have been subject to an injunction not to become attached to specific patients, and to rely instead on 'professional distance' as the organising principle of their encounters with them. To some degree this reflects the Nightingale tradition of vocational service. Ideas about nursing as an occupation fit for young ladies – as opposed to the 'domestic' service from which it proceeded (Maggs, 1987) – embodied ideas about the conduct of 'respectable' gender relations in circumstances involving physical intimacy. The emphasis on respectability, (ie. desexualising these encounters), was organised around the moral protection of the young nurse. The importance of desexualising medical encounters is not in doubt, as Emerson's (1971) study of gynaecological examinations demonstrates. However, it is also important to recognise the disruptive effects of 'emotional involvements' on the conduct of nursing work.

The organisation of nursing work on a task-allocated and routinised basis was always threatened by nurses taking too overt an interest in particular patients and being distracted from the orderly completion of their assigned tasks. As a 'system' of nursing, therefore, task-allocation relied on 'professional distance' as the principle on which the encounter between nurse and patient was organised. Nurses were expected to be committed to the efficient performance of a specified set of operations or routines – bed-making, taking temperatures, or administering drugs – rather than to specific patients. At issue here was the organisation and administration of the care of *bodies*, through the sympathetic conduct of nursing work as material practice. As Armstrong (1983a) has pointed out, this involved a view of the patient as a largely passive recipient of care.

Melia (1987), has shown that the underlying logic of task-allocation was rooted in the need for matrons and ward sisters to organise and deploy nursing staff in a way that matched work with the technical competence of particular grades of nurse. The division of labour within the ward, she suggests, was directed at deploying uncertain human resources efficiently by breaking work down into sets of tasks and routines which could easily be timetabled and supervised. This rationalisation of nurses' work was unproblematic while the central focus of medical, (and hence nurses'), work was the body as the *object* of clinical attention. However, at the point at which the patient's subjectivity – with its



attendant psychosocial problems – began to be constituted as an area of clinical interest, the strict Taylorite logic of task-allocation and the 'scientific management' of nursing work,<sup>1</sup> was irreparably undermined.

As I have suggested in chapter 2, the appeal to impersonality and efficiency incorporated in ideas about task-allocation was politically contested in the 1960s and 1970s. The thrust towards individualised nursing care and its mobilisation through systems of nursing like the nursing process, reflected – as Dingwall *et al* (1988) argue – 'a call for more holistic relationships', (1988:217); as well as the 'status anxieties of the traditional nursing elite (...) [Who] reformulated the idea of professionalism in nursing using terms which were drawn from private practice', (1988:217). It is important to note, as Dingwall and his colleagues do, that this reformulation drew on, and co-opted a medical vocabulary of assessment and diagnosis. Clearly, as an occupational group, nurses were never in a position to intrude into the capacity to diagnose bodily disorders possessed by the medical profession. What was possible, however, was to reconstitute the encounter between nurse and patient as a potentially therapeutic instrument directed at the psychosocial, and as a moment in which patients' subjectivity could be the focus for particular kinds of attention. Armstrong (1983a) has pointed to the ways in which this shift is revealed in nursing textbooks.

The reconstitution of the encounter between nurse and patient, and the re-arrangement of nurses' work to produce a more privatised mode of interaction calls into question the conflict between 'personal involvement' and 'professional distance' of the kind described by Altschul (1972) or Hockey (1976). The nurse is now required not only to administer the sick body, but to penetrate the subject. As Armstrong (1983a) has argued:

The nurse is now instructed to communicate with the patient as a subjective being: the patient must confess and the nurse listen. (...) From a simple concern with the care of the patient's bodily functions, nursing has started to become a surveillance apparatus which both monitors and evinces the patient's personal identity: in doing so it helps fabricate and

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<sup>1</sup>See Taylor, 1905; Braverman, 1974; and Thompson, 1983, for an elaboration and critique of 'scientific management.'

sustain that very identity. (1983a:459).

This focus on the subjectivity of the patient, and the demand for 'good' interpersonal relationships, means that technical competence is no longer sufficient as the basis for nursing work. The nurse is encouraged and required to act as a *subject* within *social* relationships. As the title of Armstrong's paper<sup>2</sup> suggests, this shift from a focus on the administration of bodies, to one which incorporates an interest in the social, demands the fabrication of a new basis for the encounter between nurse and patient. The injunction not to be 'involved' is suspended as nurses are required to negotiate the boundaries of intimate 'talk'.

Specific attachments or 'emotional' involvements may not be an uncommon feature of nurses' experience. However, only one respondent in this study offered an account of this type of relationship.<sup>3</sup> Despite this, virtually all respondents described themselves as being 'involved' with their patients. Here, the term was used to denote a general *quality* of nursing work: defined in terms of the respondent taking more than the physical needs of the patient into account in the course of their work. At the same time, respondents insisted that 'detachment' was a vital precondition for the assessment and management of the patient's psychosocial needs and problems. In other words, it was the contermination of 'personal' and 'professional' that was at issue, not their separation.

### 8.2.2. Involvement as a general quality of nursing practice

I want to turn now to the ways in which respondents characterised 'involvement' as underpinning their work. Again, I would emphasise that involvement in this context should not be confused with a personal attachment to a specific patient, but can be seen to be organised round ideas about how nursing work should be conducted. While Field's (1989) account of 'emotional

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<sup>2</sup>Armstrong, (1983a).

<sup>3</sup>This was given 'off the record', and I am therefore unable to reproduce it here.

involvement' is deficient for a number of reasons, he does open up the question of how involvement is constituted by deploying James' (1986) assertion that it is 'part of getting to know patients', (1986:157). James identifies the *process* through which involvement comes about by defining it in terms of a cumulative effect of a series of (often trivial) encounters in which the nurse learns about the patient as a participant in the everyday life of the ward, and through which the patient's character is revealed. I would go further than this. For respondents in this study, involvement is characterised not only as the outcome, but also as the motive which underpins nurse-patient relationships.

Nurse: It's being interested in what they've got to say, and making an effort to find out about them - when they tell you stories about their grandchildren and things like that. Trying to find out as much as you can about them, and also you've got to give a bit of yourself too, and share your interests - they'll always ask you about your family and where you live. I think you can't really say, 'I can't tell you about my personal life' - you have to give a bit of yourself to them.

Similarly:

CRM: When I was doing the pilot study<sup>4</sup> for this, nurses were saying that to nurse a patient properly they had to be involved with them - do you agree with that?

Nurse: Yes, I think you *have* to - there's no way out of it - you just can't possibly not become involved, I couldn't do my job if I wasn't.

CRM: So what does involvement mean?

Nurse: It's really just forming a relationship with people - knowing who their relatives are; getting to know what they're like; what they do - it's just that. I think that it's not just medical problems that you're treating all the time, it's a lot of psychological problems as well.

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<sup>4</sup>ie. the exploratory interviews described in chapter 4

These definitions of 'involvement' clearly do not equate directly with a specific attachment to patients, and it is difficult to differentiate them from the accounts of 'getting to know' patients that we have seen in earlier chapters. What can be seen, however, is that these accounts revolve around 'knowing' the patient as the basic imperative which underpins respondents' practice, and that 'involvement' involves a mode of addressing the patient through which this can be performed, while offering the possibility of reciprocal exchange in which the patient also comes to 'know' the nurse. We can see this exemplified in the following extract:

- |        |   |
|--------|---|
| CRM:   | What does it mean to be 'involved' do you think?  |
| Nurse: | Getting to know the patient, and allowing them to get to know you as well. And I think that any relationship, whether it's a colleague to colleague one, or a nurse-patient one, or whatever - if it's going to be meaningful to either of you - then you have to invest part of yourself in that relationship. And there are different parts of yourself that you invest in a patient, or if it's a relative or a colleague. |

This notion of 'building', 'giving' or 'investing' was emphasised by a number of respondents, and it reflects the productive capacity of the nurse to which I referred in chapter 5. It does raise the question, however, of *what* is being 'given' and 'invested'. Strong (1979), has argued that most interactions between health professionals and their patients have a bureaucratic character, by which he means that they focus principally on the impersonal conduct of a particular task, or the resolution of a specific physiological problem, and that they are defined by participants in terms of this impersonal focus. In these accounts, however, the investment of effort by nurses into 'knowing' the patient, and the possibilities for reciprocation - the patient being permitted to 'know' the nurse - undercuts the task or problem centeredness of the 'bureaucratic' encounter. This personalises interactions, although, as I have suggested in chapter 5 informality should not be confused with democratisation. In the care of the dying, this has a moral value beyond the extent to which it might relieve the routine of nursing work.

CRM: Thinking about what we've been talking about, is there a conflict between being professional and being involved?

Nurse: Yes - because we're all supposed to be professional. But, and it comes to this, if you're caring for somebody who is dying I think you have to give way to that. Because if you were just being professional you would just be doing your job and then draw the line and that's it. You'd wash them and tidy them up, and change their sheets - and you wouldn't be *giving* them anything emotionally or physically if you were just being a true professional.

The emphasis placed on 'giving' by this respondent exemplifies the ways in which 'involvement' is organised around definitions of nursing work. In this extract, it is used in the context of the provision of more than the physical care of the patient, and it points too, to the ways in which care is delivered through a personalised (ie. a non-bureaucratic) encounter. This clearly involves ideas about what it means to be a nurse and to do nursing work, as we can see in the extract below:

Nurse: I'm not always a nurse, because sometimes I come over as myself - I forget I've got my white dress on or whatever.

CRM: So, how are you different?

Nurse: Well - I don't know - I think sometimes there's barriers between a patient and a nurse - you can put up barriers, you'll accept so much but [then] enough's enough and you're a nurse from now on. But sometimes I do forget that I'm a nurse and I've got dressings to do and things like that - and just sit down and blether with them - which you *do* do as a nurse. But I think that sometimes that when you put your white hat on and the keys in your pocket, or you're doing the paperwork and the ordering, that this becomes more of a priority than looking after your patient.

Here, the respondent points to the ways in which the competing demands of her work mean that spaces have to be negotiated in which the personal encounter with the patient can be accomplished. She draws a clear distinction

between work as material practice, organised through the control of interactions which is necessary to achieve specific objectives, and a much broader definition of care that incorporates familiarity and casual conversation. The importance of being 'involved' while resisting specific attachments or entanglements, was for almost all respondents legitimated through an appeal to the 'best interests' of the patient.

CRM: Some of the nurses that I have spoken to have told me that to nurse a patient 'properly' you have to become involved with them in some way.

Nurse: Yes - I think you have to become involved according to your stress levels and ability - I personally don't. I become involved in situations like talking to relatives about prognoses to relatives, I can understand how they feel.

CRM: But you don't become especially attached?

Nurse: No, I don't - and I don't feel that I ever really have, even during my training - I think you have to stand back, and I also know my own ability as a nurse and how much I can cope with. I don't see it as a great vocation, but I also don't see it as just a 'job' - and I also don't think you can actually look at a situation and see peoples' total needs if you're so involved.

CRM: Is this something to do with professionalism?

Nurse: Yes - I think you *can* show the patient and the relatives that you're involved, but then every person deserves the same amount of time.

This notion of the patient's best interests is organised on two levels: first, at the level of the specific patient, it is important to the respondent to be able to obtain an objective view of the patient's total needs; but beyond this is also the question of the way in which particular commitments may interfere with the equal distribution of care (and division of labour), on the ward. In this latter sense, the appeal to 'best interests' is directed at the whole population of patients on the ward. The respondent goes on to affirm this:

Nurse: I see other people - other nurses - who always seem to want to nurse some patients, and who



always seem to be with them when you look; and who tend to give individual care to some patients and not to others.

[Part omitted]

Otherwise I think you're adding problems, you're always sought out by patients when you've got more important things to do - people are very sick on this ward - and I think that's very negative for the patient if they want to speak to you at a particular time. There are *other* nurses on the ward as well as you, equally well qualified. I think if you become involved it's detrimental to the patient - and the relatives - if you're not there to deal with them. It's important for them to realise that there are other people for them to go to.

If someone is dying or very ill you tend to be a bit more professional, because I think it helps them to see us as an authority who's coping and keeping [things] under control.

The appeal to social distance as a way of ensuring that the needs of patients can be assessed and met has been noted in a number of other studies (Bond, 1978, for example). But while involvement in the form of specific attachments is rejected by this respondent, as a quality or general condition of nursing work it is endorsed. For other respondents, however, even the appearance of specific attachments could be negotiated and legitimated if it meant that the patient could 'talk'.

Nurse:

There's things you have to do for the patient like bed baths and things like that - sometimes it's easier if you're that one step back from them. I've often thought it would be nice to come in as a visitor, just because they were nice people. But when you're actually doing *nursey* things, sometimes you just have to push people a little bit, and I think that if you're actually too close, or too friendly, it makes it very difficult,

You're on a fine line a wee bit: do you think your friendship is more important to the patient or do you class their well being as a wee bit more important. It's easier if you're actually a step back you know, there's no do's and but's about it, some people you've really got to push for their own good. I find that as a nurse, if I get too friendly

with a patient I find it quite difficult to be firm, I'll let them get away with a wee bit more than they should for their own good. But I'm not meaning that you should deny them your friendship because they're not doing exactly what you want them to do for their own good. But if there's somebody that finds it easier to talk to me than to another nurse - I would rather that they continued to do that - I could continue to be the nice nurse [laughs] and somebody else could be the nasty nurse that would be the one that really had to push it. I wouldn't ever want to damage a friendship if I was the one person they really wanted to talk to - (but) sometimes you've got to push people - there's no point in letting them lie in bed and dwell on misery and things like that. Give them the opportunity to talk yes, but we do our best to buck their spirits up if they're well enough.

In this account we can see how the disciplinary function of nursing work may be suspended or redistributed to effect a set of conditions in which the patient can be encouraged to 'talk'. But we can also see that the respondent's more usual mode of apprehending the patient is organised around 'detachment' to ensure that personal interests and occupational objectives do not become confused. As we have seen in other accounts, this stress on disentanglement is legitimised through a set of ideas about what is in the best interests of the patient - the nurse having a 'total' perspective of the patient's needs. This respondent affirms the importance of this perspective, and points to the ways in which responding to these may involve *not* 'talking', and the distraction of the patient from the implications of her disorder. The central place assigned to 'talk' by respondents and the emphasis which they placed on the construction of relationships and encounters in which 'talk' can be undertaken, needs to be set against a range of factors that inhibit the mobilisation of involvement as a general quality of nursing work. As I observed in chapter 5, interactions between nurse and patient are episodic and discontinuous; changing work rosters, holidays, transfers and the demands of other work on the ward all act to break down sustained contact between the nurse and patient. While this makes it difficult to engage in specific attachments to patients, its effect on involvement as a general quality was seen by some respondents to lie in the ways in which it affected patients' perceptions of the nurse.

Nurse:

I think it must be incredibly frustrating for a patient to see *so many* faces. And one of the things I always do is introduce myself by name, and several patients have said to me 'you're the first person that has ever done that for me'. When you think of the number of nurses patients come across in a day, or in a stay, I think it's awful - which is the whole point behind primary nursing - which is, as you know, the trendy thing to be into. But is practically so difficult to do in the sort of set-up that we've got now. To me that would be a far more satisfying form of nursing. I find it's frustrating doing little bits for different patients and never doing anything properly, and often not being able to really relate to a patient.

I often feel - *why* should a patient give me their fears and worries, or make themselves vulnerable when they know perfectly well that they might not see me for another two or three days - or if they do see me I'm just passing through, because I'm not actually working in their area. In some ways it makes me reluctant to probe and to ask questions that a nurse should be asking - particularly of somebody who's perhaps been diagnosed as having a terminal illness. What right have I got to expect them to make themselves vulnerable, when they're not going to see me again, or it's just going to be a very superficial contact. And I think patients are protective of themselves, and not unreasonably so.

In this account, the nurse focuses on the ways in which the organisation of work inhibits the mobilisation of involvement as a *quality* of practice. For her, this is about the delivery of care which can only be accomplished through a more sustained contact - and the absence of this inhibits 'talk'. Davis (1984) has argued that 'lack of time' and 'pressure of work' have conventionally been deployed by nurses to account for their failure to conduct 'good' interpersonal relationships with patients. Although there is no doubt that nurses are subject to the pressures and demands of competing work, and while their encounters with patients are disrupted and discontinuous for a variety of reasons, we have to ask why - given this disruption and discontinuity - are involvement and interpersonal relations given such a central place in nurses' accounts of their work in this context?

The first point that I wish to make here is that these accounts are essentially about the moral basis of the delivery of care to the patient. 'Emotional

entanglements' are resisted and avoided to sustain a definition of relationships that is unambiguously connected to the performance of nursing work, and which in turn accords both sets of participants a particular (and sustainable), status in interactions. 'Good' relationships, therefore, are those in which the 'involved' nurse is able to effect interactions in which 'talk' is performed and in which the patient is 'known' as a subject, without undermining her own status as an authoritative administrator of the patient's career.

Second, I would argue that it would be a mistake to view this solely as an instrumental strategy. The mobilisation of 'involvement' *is* about effecting a relationship in which a therapeutic gaze can be directed at the patient to excavate and reveal subjective features. However, it also confers a benefit on the nurse by offering a powerful set of ideas through which value and meaning may be assigned to nursing practice. Here, technical competence in material practice – in pain control, for example – has its counterpart in the social competence of the nurse to identify and respond to patients' intimate needs and fears. As a therapeutic technology, the relationship between nurse and patient opens up a realm of practice which is seen by respondents as qualitatively better because it allows more to be achieved for the patient. (The obvious point to make here is that informal, friendly relations between nurse and patient are also more enjoyable than those which are impersonal and bureaucratic.) In doing so, it meets the demands of those interventions (like the nursing process), which attempt to individualise patient care and which attempt to address non-physiological problems. Establishing a 'good' relationship is demanded in the same way that nursing the patient also demands an effective regime of physical care, (but with the advantage that if the patient rejects this, it is – unlike a medication error – not the responsibility of the nurse). The contermination of physical and psychological comfort, as Dingwall *et al* (1988) point out, has additional effects.

To the extent that more of the patient's self is engaged, the opportunities for influencing behaviour may be increased. But this individualisation of patient care is not only a way of disciplining the patient: it can also be a way of disciplining the nurse. Any attempt to pursue her own interests in the organisation becomes a breach of trust. In this way the nursing process can be used to divide nurses from one another and to erode their commitment to any industrial goal. Personal objectives become confused with those of the occupation or organisation. The recent proposals for primary nursing represent

the most logical extreme of this movement. (1988:220).

While the personal moral responsibility for the patient which is assigned to the nurse through systems of individualised patient care does rely on the contermination of personal and occupational interest, this seems to me to be for reasons other than that of 'disciplining nurses'.<sup>5</sup> As we saw in the discussion of Melia's (1981) study of the socialisation of student nurses in chapter 2, the distantiation of personal pursuits is accomplished through an elaborate set of moral pressures and responsibilities that centre on the material practice of nursing work. The importance of being seen to 'pull one's weight' in co-operation with other nurses acts as a powerful constraint on individual conduct, and I would argue that self-regulation through conformity to ideas about what constitutes work, rather than the inculcation of personal responsibility to specific patients in systems of individualised nursing care acts as the disciplinary *mode*. In other words, it is nurses being pulled *together* rather than separated which holds the pursuit of personal objectives in check. We can see something of this in the extract from an exploratory interview below.

Nurse:

Nurses have no real training in counselling - as do people whose jobs depend on communications skills and counselling - my course in [name] was one of a kind, and not all that popular. The response of those who didn't go was that it was a waste of time - but not [of] those who went on it - the prevailing atmosphere was that you were wasting time if you weren't doing something, and

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<sup>5</sup>Nor does it seem to me to be any more a barrier to the pursuit of industrial 'goals' - by which I understand Dingwall and his colleagues to mean industrial action - than the ideology of selfless vocational service which remains an important element of discourse about nursing, even if its significance within the occupation may have declined. Nurses have traditionally been reluctant to resist falling standards of pay and conditions of service in ways that deny their services to patients, and unionisation within the occupation has been hindered by the appeal of professional status and the existence of the Royal Colleges, as well as by the mobility of nurses within the occupation and its more general demography. The situation is, of course, entirely different in the US where nurses' strikes are not unknown. In the UK resistance to low wages and poor working conditions has largely been expressed by nurses moving out of the occupation altogether, or failing to return after career breaks. However, at the time of writing at least 15 nurses are under investigation in England and Wales for alleged professional misconduct after participating in strike action over the 1988 clinical grading exercise, (Nursing Times, 14 August, 1990)



that talking wasn't doing something.<sup>6</sup>

It could be argued, in fact, that ideas about individualised nursing care – *if* they are put into practice – have precisely the opposite effect, acting to emancipate the nurse from a definition of nursing that is organised through the impersonal performance of routine tasks.

### 8.3. Subjectivity and culpability

Respondents in this study endorsed the view that their work involved more than the resolution of aspects of the patient's physical condition. Nursing work in this context included attempts to individualise patient care and to address patients' psychosocial problems. However, while task-allocation demanded that groups of nurses co-operated to meet predefined material objectives, through what Melia (1987) has called 'pulling together' (1987:45); in the shift to 'patient centered' work organisation the nurse has to negotiate the boundaries between collective and individual action. In other words, while the objectives of material practice were and are established through group norms, how much the nurse invests in the formulation of relationships with patients is now a matter of personal initiative.

In being 'involved' and working to construct a 'personal' relationship with patients the nurse is now required not only to judge the patient's needs and wants, but also to inspect the state of her relationship with him. 'Problem' oriented nursing practice thus has the effect of rendering relationships between nurses and patients problematic in themselves.

Nurse:

Sometimes you hide behind what you do to them, you make out you don't have time to talk. It keeps you busy. *It is quite hard to talk to people who are dying* – depending on what kind of people they are as well. If they're angry it's very hard to deal with and you tend not to talk to them as much as

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<sup>6</sup>This nurse did not work at the hospital in which the main body of interviews was conducted, and had recently left a hospital at which the Nursing Process had not yet been introduced.



you would with someone who's receptive and responsive. Often they just don't want to know you. They just turn their backs and that's it, you can't get through.

As we have seen, the patient who does not wish to be 'known' or to 'talk' presents the nurse with a problematic figure. 'Involvement' as an imperative underpinning a mode of address which individualises and personalises the encounter between nurse and patient, is organised around the notion that the patient *should* be 'talking' to the nurse. The failure of the patient to open themselves up is, at one level, constituted as the moral responsibility of the nurse.

Nurse:

Some patients aren't willing to give much away or don't want to speak to you, they maybe don't like you. And (then) it might be better if someone else spoke to them. I think it depends on the patient, and on yourself too - how much you're willing to give, and you can gauge it from there when to stop. You know - they usually give you guidelines and say 'I've had enough' or 'I don't want to speak about this'.

Because 'knowing' patients and 'involvement' are so intimately linked, the patient who will not permit herself to be known and with whom 'talk' cannot be conducted represents an obstacle to the kinds of nursing practice informed by the imperative towards a non-bureaucratic and individualised encounter. The patient who is unwilling to open themselves up to the therapeutic gaze of one nurse may be approached by others, but because 'talk' is a voluntary activity for both participants it is also possible to negotiate, (and renegotiate), its boundaries. The way in which 'involvement' demands this negotiation of boundaries relates both to the specific encounter and the nurse's awareness of the patient's trajectory. Respondents emphasised the ways in which individualised nursing care, with its inherent emphasis on the social needs of the patient could lead to problematic relations with them.

Nurse:

I would probably class my own emotional state as just as important as theirs - because if you're

emotionally exhausted you're going to be absolutely no good to them or to anybody. I felt with the patient I've just mentioned<sup>7</sup> that I would be better taking a breather for a while and then I would be better equipped to handle it later on. I think we all guessed that things would go from bad to worse anyway, and I think in retrospect that I made the right decision. But it was quite hard at the time. I think it as an unconscious decision, because I was aware of having done it before I realised what I was actually doing.

I think in a way that there is part of it that is instinctive – because I haven't dealt with that many deaths compared to other people. I'd never been involved with somebody who was that young and who was going to die. I realised what I had done afterwards – it was probably the right decision.

I would hope that I *can* be there, and I like to show that I care for the person – I make a point, if I hear that somebody's not been well when I come on shift, of going to see them before Report – just to show that they *are* important to me. But having said that, I don't think it does anybody any good to become too emotionally involved – but I wouldn't want anybody to think that I was cold or callous or anything.

Working out the balance between the 'personal' and the 'professional' was a critical issue for a number of respondents. In the example above, we can see a description of how the nurse achieved this in practice, and of its moral basis. The need to 'care' and to be 'involved' without becoming emotionally entangled with the patient is organised around the demand to be useful – that is, the capacity to undertake the material practice of nursing work effectively and without distraction at critical junctures in the patient's career. The importance of resisting what Altschul (1972:9) has called 'emotional entanglements' for this reason, is emphasised in the extract below:

**Nurse:** It's always something that you reflect upon because there are always patients which will stick

<sup>7</sup> This patient had been admitted with a kidney tumour. Sadly, secondary tumours had rapidly developed and spread throughout the body.

in your mind - and who you worry about - and these are the patients who you become emotionally involved with. But your emotional involvements with patients are of a different type to those that you would have with your family, say. I can see the argument for your not becoming emotionally involved to the extent that you cannot detach yourself from the situation.

CRM: There's a very fine line isn't there?

Nurse: *Oh yes*, and I'm sure that once you've had to deal with that situation you become more proficient at dealing with it. But I'm sure that there are patients who you do become involved with, and who cannot be eradicated from your mind.

Similarly:

CRM: I was going to ask, do you think there's a conflict between what's expected of you as a professional, when you say that you're involved but at the same time detached?

Nurse: No. I think that's just what I think about being detached and objective it's just one aspect of it. I don't think you can fully assess anybody if you're not subjective as well. I think there's a subjective element in dealing with somebody's emotions. You can't deal with all that objectively, you've got to put in your own feelings, but I think that's where it's important to be working within a team, because of your feelings about a person. They are inevitably subjective, but by the time that you add together you and your colleagues feelings you probably come up with a more objective view. You agree and you disagree, and you're inevitably assessing somebody with your own prejudices. But everybody tends to have different prejudices so you can usually come up with a fair assessment using everybody's.

CRM: I was going to ask what happens when you disagree about how to handle a patient, I mean, how does it get negotiated?

Nurse: I think that at the end of the day everybody to some extent approaches the patient the way that they feel about it so you may have a bit of conflict if you're all doing it differently. And you may find there is somebody who just can't handle a patient, they just can't handle their personality. You usually find someone in the ward area can. That's what I've generally found. Somebody really annoys me and sort of somebody else says "oh they don't bother me I'm quite happy." So, you do, (it) sounds

dreadful but it's only human. You do avoid the odd patient, because you just can't give them fair treatment if you don't just get on with them as a person. But with the number of staff that are on duty somebody else can, so you let them deal with that patient.

CRM:

What kinds of patient annoys you then?

Nurse:

It's hard to think offhand. Generally I do manage. I mean even when I *know* someone is annoying me. I think I generally feel that I manage to say "well they're behaving like that *because*" and if I can find a reason why they're behaving so obnoxiously then I can deal with it. And I can ignore them being offhand, nasty, demanding. You know, everybody likes to feel that they're being appreciated and likes their pleases and thank yous. When you get a patient who just shouts and demands attention whatever else you're doing for other people, you can get a bit annoyed with them. I usually feel that if I can look at the patient and say well, they're behaving like that *because* - I mean, I can remember one patient who was like that.

[Part omitted]

And having rationalised it, then, I could accept her behaviour wasn't personal to myself. If I can accept nasty behaviour is not personal towards me then I can accept it, and it can sort of blow over me like water off a ducks back. I don't get annoyed at being shouted at, sworn at, or anything else as long as I don't feel it's me personally. If it's as a nurse - if it's at the world in general if it's this accident that happened to me, fine, shout all you like, it'll not upset me, but I've got to find out the reason why. And then I'll generally feel that I can handle whatever they like to throw at me [laughs]. but I don't think it's true for everyone, I know it's not true for everybody 'cause I've seen these others say, "oh she's all right she's only shouting because" and "I can't stand her" but I find that I manage to do that.

While dressings can be changed in interactions which demand the minimum of verbal interaction, the penetration of the patient's intimate disposition requires a much greater depth to social interactions. Here, the contermination of 'personal' and 'professional' means that nurses' feelings about the patient must exert an influence on the care that they receive.

Issues of compliance and legitimation have always been important elements in the typification of 'good' and 'bad' patients, as Kelly and May (1982) and Heyman and Shaw (1984) have pointed out. And these problems are raised in the extract above, where the respondent points to the ways in which patients do present extreme and difficult behavioural problems. The shift towards individualised care – which attempts to address the patient's psychosocial problems – adds a new dimension to this. While the 'bad' patient continues to represent a problem in the nurse's negotiation of the orderly conduct of concrete tasks, (and at a broader level, in the disruption of the social order of the ward), non-compliance and non-legitimation are not longer just interactional problems. The nurse is now required to rationalise and understand them in terms of the patient's *culpability*.

Underlying this is the notion that some behavioural problems which patients present to the nurse can be considered *natural*. The patient who is angry because of feelings of frustration and helplessness in the face of pain and loss of independence is 'understandable'. The subjectivity of the 'naturally' problematic patient is revealed not by self-reporting in talk – in the confessional encounter which I suggested in the concluding discussion to chapter 6 – but in the ways in which the absence of 'talk' is manifested. Thus, behavioural disturbance is reconstituted as a subjective symptom which, once revealed, may respond to the therapeutic intervention of another nurse. Against this, are set those disturbances and disruptions for which the patient may be held morally responsible

CRM: Do you set limits on relationships – do you say there is a point after which I will not go?

Nurse: Not really, no. I think, again, it depends on the patient. Some of the men sometimes get a bit too familiar, and you set limits then – with student nurses – you know what they think, student nurses and things like that. You have to watch what they say. But how friendly you get, not really, no.

CRM: What kinds of people do you get friendly with?

Nurse: *Nice people*, [laughs] One who says please and thank you and is grateful for what you do for them. You tend to like people like that – they can be cantankerous and whatever, but you do get to like them. *Usually*, the rest of our patients I do, but there are some you don't like. Again, it depends

on the person, you get some who are unpleasant people. Not necessarily because they are unco-operative, but just *unpleasant people, rude people* that you could meet anywhere.

In this description the routine and legitimate body of unproblematic patients, (Dingwall and Murray, 1983) are distinguished from the 'cantankerous', (whose problematic behaviour is acceptable), and those for whom disturbance and disruption are not rationalisable in terms of their subjective response to a physiological condition. This distinction between *understandable* and *undesirable* is built into the set of ideas which underpin the re-allocation of problematic patients to other nurses. In the following extract, a question about the avoidance of 'emotional entanglements' leads directly to an account of the ways in which this distinction is dealt with in practice.

CRM: Are there ways in which you can organise your work to maintain that detachment?

Nurse: Aye, you can do that also with patients that you don't wish to be confronted with. Because there are people who antagonise you, and therefore it's better for you and better for the patient that you organise your work in a way that means that the care is done by somebody else.

CRM: And that can be done?

Nurse: I think so - as long as it's identified that there's a reason behind it, and that it's not that a member of staff will not be with this patient because they happen to be unpopular. I think, yes, you have to be able to organise the plan for the day to accommodate that - because it will happen. Not every nurse will get on with every patient. Not every patient will like every nurse, which is perhaps more important.

I think it's all in how well you know the individual patient. If you've got a relationship with them beforehand then you tend to follow this through, and you always come and talk to them whenever you come on duty - you can see them beckoning you. It's all in the relationship that you've built up; they always get on better with one nurse. They always do, so they tend to be the one's that find out the problems, and can then discuss what we can do about things.



Again, this nurse stresses the distinction between those patients who represent intersubjective problems, and those who 'happen to be unpopular'. While the former present problems that can be dealt with through the re-allocation of staff, the latter are 'inevitable' and irresolvable. This emphasis on the inevitability of interactional problems with 'bad' patients is mitigated by the possibility that 'involvement' – the investment of effort into building relationships with the patient – can create a set of conditions in which subjective responses to the experience of illness can be revealed and resolved. This emphasis renders not only the subjectivity of the patient problematic, (the undesirable patient is culpable), but also that of the nurse. The nurse who fails to rationalise and assess the degree to which problematic behaviour is understandable, is also culpable. This is directly connected to a view of nursing work which gives the subjectivity of the patient some priority,<sup>8</sup> and which incorporates attempts to understand the patient's subjective and idiosyncratic character to meet a set of objectives.

CRM: A number of nurses that I spoke to defined *proper* nursing as something that happened when they were 'involved' with the patient – what do you think that means?

Nurse: I suppose what it means is that to a certain extent you can predict what the patient's needs are. Because over a period of time you've gotten to know them, how they tick almost, and therefore you can almost predict what they will want.

To a certain extent you can almost predict that their personality is such that although that's what they want, they will not ask because they feel that they are putting you out. So you can structure your approach to the patient in order that you can get that kind of information from them – you can let them know that you've got an idea of what they're after and what they want. So I think that being involved in your patient is *knowing* them to the extent that you can almost predict the things that they actually want.

That's a very difficult thing to do, some people will say that they've been married to someone for 50

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<sup>8</sup> Although the extent to which this is undertaken cannot be assessed in this study

years and still can't predict what they want. At the same time, we see people at their most vulnerable, and therefore perhaps we get to pick up slightly more detailed information than those who haven't seen them in that kind of situation.

The imperative to *be* involved and to *know* the patient so that 'needs' and 'problems' can be assessed and resolved is about the production of a particular view of the patient's subjectivity. It involves the deployment of a set of ideas that are directed not only at ensuring that interactions are not disorderly, but which establish the patient's docility. It is important to make the distinction here between docility and passivity. Involvement is not about organising the patient as the passive recipient of different kinds of intervention, but rather about defining the field in which he or she may be legitimately incorporated into the operation of these interventions – for example, in self-reporting a particular anxiety about pain control or about the future of his or her spouse – as an active co-respondent. It has a criterion of success – conduct through which the co-operative exposure and resolution of problems and the meeting of needs through the revelation of the self may be achieved.

#### **8.4. The boundaries of the nurse-patient relationship**

In this chapter I have advanced the argument that respondents' ideas about 'involvement' and 'individualisation' have a direct and intimate connection to a view of the subject as a legitimate field of nursing work. The emphasis given to psychosocial needs and problems demands that the nurse effect their revelation through 'talk'. As I have suggested, this has its corollary in ideas about investment and culpability. The individual patient has a responsibility to accept *individual* care: and just as the patient who fails to co-operate with the administration of care of the body<sup>9</sup> is held responsible for his or her actions, the patient who denies or obstructs the nurse's investment of effort into the construction of personal relationships in which self-revelation may be performed is open to judgements about culpability.

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<sup>9</sup>The Jehovah's Witness who refuses a blood transfusion, for example.

However, although nurses give these efforts to effect 'good' relationships a central place in their accounts, they are confronted by a number of problems.

- There is evidence that some patients do not regard 'talk' with nurses as appropriate.
- A set of 'structural' or 'environmental' constraints operate to limit the extent to which the patient can become 'known' and 'talk' performed.
- The individualisation of patient care and the focus on the psychosocial means that the nurse's personal feelings about the patient have an impact on patient care. In other words, the subjectivity of patient *and* nurse are rendered problematic.

Because of these contextual boundaries in the configuration of relations between nurses and patients, it is important not to over-extend the line of argument that I have taken in this chapter. I have privileged the intersubjective over the *interobjective*, and have largely passed over the way in which the patient's body occupies the centre of the nurse's attention. In directing attention away from the way in which nurses undertake work which is about the observation and maintenance of the body, and which attends to the patient's physical care and comfort, I do not wish to suggest that this is a subsidiary or secondary effort. The care of the body is the *primary* focus of nursing work. However, I think it can be argued that 'involvement' is also about efforts to apprehend the patient's public life as a social actor and about attempts to penetrate the private sphere of her subjectivity. The co-option of a medical discourse that specifies a set of features of the subject that are of medical therapeutic concern demands its monitoring or surveillance, and the formulation of practices and techniques through which these may be revealed and resolved. The critical point that needs to be made here is that while the balance of 'personal' and 'professional' or 'involvement' and 'detachment' which nurses endorsed may be seen as part of a strategy through which surveillance may be undertaken, it is also practically very difficult to implement.

A more potent mode of surveillance may not be the only effect of 'involvement'. In their discussion of sociological aspects of marriage Berger and Kellner (1979) have pointed to the ways in which partners work to jointly construct a shared reality, to reconstruct the present and create a 'commonly

projected future', (1979:40). For Berger and Kellner, marriage offers a 'decisive phase of socialisation', (1979:37) for which the major resource drawn on by partners is daily conversation in which a shared understanding of the world is constructed. They argue that:

Every individual requires the ongoing validation of his world, including crucially the validation of his identity and place in this world by those few who are his truly significant others. (...) In everyday life the principal method involved is speech. In this sense it is proper to view the individual's relationships with his significant others as an ongoing conversation. As the latter occurs it validates over and over again the fundamental definitions of reality (...) by taking the definitions silently for granted (...) Through the same conversation the individual is also made capable of adjusting to changing and new contexts in his biography. (1979:29).

Berger and Kellner's argument has important implications for a sociological analysis of the relationship between the 'involved' nurse and patient. At the end of chapter 7, I pointed to the way in which nurses engage with the patient not as agents of a 'gaze' or discourse, but as subjects, and I emphasised the precarious nature of these intersubjective relations. 'Detachment' in this context makes sense, not only as a mode from which problems and needs can be identified in their 'totality', but as a position from which the nurse is able to resist being 'sucked in' to the patient's version of reality. The unequal configuration of the nurse-patient relationship, and the limited forms of reciprocation which the nurse permits in conversation directed at 'knowing' the patient and in 'showing' that she cares, confirms the dominance of *her* reality. In maintaining a relationship in which 'talk' can be conducted the nurse continually validates the patient's experience and through her taking the patient's status *qua* patient for granted, defines and projects its presence and trajectory. Again, the patient who resists attempts at being known is problematic not only because she reflects the therapeutic gaze, but because incorporating her into the ongoing social reality of the ward - and thus ensuring her compliance and legitimation - is resisted.

Involvement, then, is not simply about ensuring the individualisation of patient care and the excavation of the patient as a subject. It is about redefining the patient as an actor through particular kinds of interaction that evince the

nurse's definition of her work and of the social context in which it takes place.

## CHAPTER 9

## NURSING WORK AND THE SUBJECTIFICATION OF THE PATIENT

## 9.1. Introduction

In this thesis, my concern has been to explore the ways in which a group of staff nurses defined, understood and accorded significance to their relationships with terminally ill patients. This set of specific questions, however, is underpinned by a more general sociological interest in the ways in which personal relationships are configured in conditions which are defined as being in some sense problematic by participants. Following on from this, I was interested in the practical ways in which actors attempt to accomplish the resolution of these conditions. In this concluding chapter I want to address these issues in greater depth than has been the case in preceding chapters.

## 9.2. The trajectory of the subject

In discussing respondents' accounts I have used the patient's trajectory or career as a device through which shifts in the focus of nurses' attention and the changing configuration of relationships with terminally ill patients can be charted. The starting point for my discussion in this chapter is the direct and intimate connection between nursing *work* and nurse-patient *relationships* that is revealed in these accounts.

In chapter 1, I noted how at the inception of this study I made a demarcation between public and private, and formal and informal encounters. I now view these distinctions as somewhat misplaced – but not entirely so – because, as we have seen, the patient's progress through his or her institutional career and organic trajectory is marked by shifts in the way in which the nurse-patient relationship mediates the performance of conversational and material practices, and is ordered by the occupation of particular spaces.

In chapter 5, I have presented accounts through which the connection between work and relationships can be established by examining the period immediately after the patient's admission to the ward. Nurses mobilise a range of practices through which the production, collation and deployment of different



knowledges about the patient is undertaken. The manufacture and distribution of these knowledges has the effect of defining the patient's social and organic character, and does so in two distinctive ways.

First, by establishing the patient's status as the public object of clinical attention and administrative procedure, that is, as a *body* to be manipulated and modified. The patient exhibits and describes specifiable signs and symptoms which may be observed and charted, and through these localised observations the relationship between her and a range of material practices and practitioners is designated and activated. As a public character the patient is reduced to a set of elemental categories: as a body specified by its pathological state; as an actor implicated in particular social relationships and with access to different resources beyond the hospital; and as an actor responding to the regime of the ward cheerfully, stoically, with complaint and so forth. Against these typifications, the possibility of the normalisation of the body and the patient's consequent return to the world beyond the hospital is measured. This disassembly of the visible and interpreted character of the patient is characterised by what Foucault has called the clinical gaze, through which the abnormality of the body is defined in relation to its individual character through the application of knowledge about *bodies* as general phenomena. It is by way of, and in relation to, the production of a taxonomy of the elements of the public character of the patient that the practices through which its normalisation is attempted are specified.

Second, the nurse addresses the patient's private sphere. If it is the question 'what?' that is directed at the body to define its organic state and 'how?' to determine the basis of its disorder, then the question 'who?' is addressed to the disassembled public character of the patient to resolve the problem of its individuality. This raises the possibility of the nurse 'knowing' who 'Mrs Jones *really* is'. Here, 'knowing' is predicated on the notion that the patient's clinical disassembly has the effect of mystifying her 'real' or 'authentic' character. It follows from this that the deployment of practices that *give* to Mrs Jones the status of a 'real' or 'authentic' 'whole' character, and which re-assemble her, offer the possibility at least of exposing her intimate disposition and biography. So, as I pointed out in chapter 5, just as there is a clinical gaze which makes intelligible the objective character of the patient, there is also a therapeutic gaze which rationalises her social history and present, and through which the nurse can *make sense* of her.

This problematisation of the subject emerges in the data presented in chapter 6. Here, the nurse's field of discretion is at its most constricted, yet particular dimensions of the patient's subjectivity are under scrutiny. Her response to uncertainty, the exhibition of anxiety and the extent to which she is judged to want to 'know' about her diagnosis and prognosis are examined and contested by groups of actors – medical staff, nurses, relatives and others – who each have their own agenda for decision making about disclosure and criteria through which they sustain and explain particular courses of action. Although the nurse 'knows' the patient, the extent to which this knowledge can be deployed and given concrete effects depends on the extent to which other actors admit her to the decision making apparatus. If the period in which prognoses are decided upon and confirmed is characterised by the greatest extent of medical constraint on the nurse, then its disclosure to the patient has the liberating effect of opening up a new sphere of work. The formal announcement of a terminal prognosis not only defines the trajectory of the body, but it also designates a new relationship between the patient and medical staff. The latter can no longer offer the restoration of the body, but instead are restricted to its palliative maintenance. In chapter 7, we see that after this formal and ceremonial encounter nurses' descriptions of their encounters with the terminally ill almost entirely exclude medical staff. It is in this period of the patient's career that new practices are opened up, through which the therapeutic gaze can be mobilised to its greatest extent, and in which the nurse is left alone with the patient to comfort and to counsel.

The mobilisation of the therapeutic gaze demands the privatisation of encounters. In consequence, the exchanges in which the nurse mediates medical knowledge about the body and in which the patient reflects on its meanings and implications are excluded from the public arena of the ward. The nurse-patient relationship is reinstated privately in new social spaces that define the significant character of their occupants. While the extent of bodily disorders is dissected publicly, the revelation of their experience is undertaken in seclusion. This is emphasised by the way in which conversational rather than material practice comes to be given an emphatic and central place in nurses' accounts. 'Talking and listening' is stressed as the outcome of practices which effect the 'knowing' of patients and the engineering of 'involved' and 'personal' relationships. But although these encounters are rendered through a vocabulary of individualisation they have a set of routinised intentions and objectives, to search out psychosocial problems and emotional crises. This work relies on the

patient voluntarily opening up to the nurse's view her subjective state:

the subject is thus made visible and accorded significance as a site of labour. Once the body no longer offers the possibility of restoration and rehabilitation, the normalisation of the conscious subject is given priority.

This normalisation of the subject revolves around the elimination of private fears and needs, and the integration of the patient into the dying trajectory. In 'talking and listening' the prospect of death and its mechanisms are resolved through encounters that have the quality of the *confessional*. But this confessional encounter is itself riven with oppositions: between the irrecoverable decline of the body and the resolution of problems of the subject; between its individualisation and routinisation; and between the natural and the culpable.

Throughout his career, then, the patient's subjectivity is accorded significance in relation to the trajectory of the body. 'Impersonal' bureaucratic encounters are displaced, first by 'personal' relationships which constitute the patient as an individual, and finally by the mobilisation of the therapeutic gaze at its most focused – through which the nurse attempts to reveal the underlying reality of the patient's experience and authentic disposition. Friendly and familiar encounters are transformed into the *site* of work rather than as a relief from its routines. 'Who are you?' is displaced first by 'how do you feel?' and finally by 'do you want to talk?' But this raises the question of the derivation of the nurse's authority to direct this gaze, and of the power to enter into the realm of the subject. It is to this question that I now wish to turn.

### 9.3. Foucault: pastoral power and the vitality of the confession

In stressing the importance of 'talk' between the nurse and patient, I have pointed to the ways in which it seems to take on some of the qualities of the confessional – by way of what Bloor and McIntosh (1990) have called surveillance by proxy – and to be formulated within what approximates to a pastoral relationship. In the discussion which follows, I draw on Foucault's (1986) discussion of pastoral *power* to explore the derivation and effect of this mode of constituting social relationships.

As Wickham (1986) has observed, for Foucault power is not an objective

phenomenon, but rather a *quality* of the discourses and practices through which social relationships are activated, and as such exists only in the moment of its exercise. Foucault insists on the importance and vitality of pastoral power as a quality of the relationship between institutions which rely on surveillance and their subjects.

The exercise of power consists in guiding the possibility of conduct and putting in order the possible outcomes. Basically, power is less a confrontation between two adversaries or the linking of one to another than a question of government. This word must be allowed the very broad meaning which it had in the sixteenth century. 'Government' did not only refer to political structures or to the management of states; rather it designated the way in which the conduct of individuals might be directed: the government of children, of souls (...) of the sick. (...) To govern, in this sense is to structure the possible field of action of others. (1986:221)

Pastoral power, and the fields of possible conduct that this opens up, should be disconnected from the specific ecclesiastical connotations of the term. The decline in the significance and influence of the ecclesiastical *pastorate*<sup>1</sup> has its counterpart in the emergence of new institutions which practice surveillance (medicine, penal systems and so forth), on the subject, and which by deploying what Foucault terms the 'human sciences' seek to understand, localise and interpret individual intentions, motives and experiences. In the emergence of these institutions the mobilisation of pastoral power is transformed. The object of its exercise is no longer the surveillance of the conscience and the modification of intentions to ensure salvation in the next world. Instead, new actors have appropriated its function to penetrate the subject in the here and now, and to effect its normalisation and integration in relation to a particular body of ideas about what constitutes emotional well-being.

Foucault emphasises the part that the development of psychiatric medicine has played in this historical transformation. As psychiatric, psychoanalytic and psychotherapeutic ideas have gained currency and spilled over into the wider

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<sup>1</sup>By which, I think, Foucault focuses on the ecclesiastical institutions and practices of Roman Catholicism.

culture, they have become sedimented into the knowledge bases of a new range of 'helping' and therapeutic professions that have taken on the role of guiding the conduct of living. Nursing is just one of these although, of course, it has a more formal and direct relation to medicine. As the human sciences have grown, the interpretation of the interior life of the individual – what Lasch (1980:3) places under the general heading of 'the social invasion of the self' – has come to dominate their effects. We have already seen some of this in my discussion of the knowledge base of nursing in chapter 2, and also in my account of Bergen and Arney (1984) from chapter 5 onwards. For both the Christian pastorate and the new normalising and individualising professions, this subjectifying power cannot be:

exercised without knowing the insides of people's minds (...) making them reveal their innermost secrets (...) [And] is linked to the production of truth – the truth of the individual himself. (1986:214)

Pastoral power, then, finds its expression in a therapeutic gaze directed at the production of truth about the subject. Through being 'known' and through 'talking and listening' the patient is encouraged to give voice to her private and authentic concerns – and so to produce and expose her own truth. This involves a view of the nurse's relationship with the patient as the site of work and which specifies the sort of conduct that should be engineered within it. Caring for the 'whole' patient is, of course, to some extent contingent – not only on the extent to which the patient disposes to reveal the truth about herself, (and the patient has the power to contest the nurse's definition of her work, and to resist the activation of pastoral power through *concealment*) – but also on the various structural and environmental discontinuities and constraints that are imposed on the encounter between them, and which I have outlined elsewhere. In this sense, there is not only a direct and intimate connection between 'work' and 'relationships' but for all practical purposes the two are indivisible. The relationship between the nurse and the terminal patient is the site in which that which is to be normalised is revealed.

The Foucauldian explanation of the pastoral and confessional qualities of the encounter between nurse and patient is compelling in the way in which it evinces the connections between a range of practices and their effects. The problematisation of the subject in the human sciences leads to the erection of



institutions through which the surveillance of subjects may be undertaken. In turn, this leads to the manufacture of the confessional encounter as the dramatic act through which the authentic state of the subject – its interior truth and peculiar logic – may be revealed. This has its counterpart in the emergence of techniques through which this authentic state may be addressed, and thus through which subjects may be normalised and integrated into particular trajectories as individuals.

#### 9.4. The therapeutic enterprise and the order of the patient's career

I want to shift the focus of my discussion at this point, away from the elevated explanation of the confession that Foucault offers, and to take a more micro-sociological and actor-oriented view. Even so, I would argue that this is by no means incompatible with the Foucauldian line that I have taken in the preceding discussion. At the outset, I want to reaffirm the point that I made in the conclusion to chapter 8. I suggested there that a more potent mode of surveillance might not be the only effect of the mobilisation of ideas about involvement as the basis for respondents' practice. The nurse is also involved in defining and adjusting the social reality of disorder as it is understood by the patient, and explaining the meaning of events and experiences to her. Turning again to Berger and Kellner's (1976) essay on the sociology of marriage, we can see that they argue that:

Ever since Durkheim it has been a commonplace of family sociology that marriage serves as a protection against anomie for the individual. Interesting and pragmatically useful though this insight is, it is but the negative side of a phenomena of much broader significance. If one speaks of *anomic* states then one ought properly to investigate the *nomie* states that by their absence lead to the aforementioned states. (...) Marriage is obviously only *one* social relationship in which this process of *nomos* building takes place. (1976:27)

As I have already noted, Berger and Kellner's argument has obvious significance for any study of the nurse-patient relationship. This relationship also involves *nomos* building, although this is clearly in a more episodic, contingent and less sustained form. Here, the relationship between nurse and patient is the site of the explication of redefined social realities, and the construction of new norms of behaviour. Like all forms of socialisation, this is essentially about the



integration of the actor, the rendering of appropriate behaviour and the normalising of particular experiences. As Berger and Luckmann (1966) argue:

socialisation internalises a reality apprehended as inevitable. This internalisation is deemed successful if this sense of inevitability is present most of the time, at least while the individual is active in the world of everyday life. But, even when the world of everyday life retains its massive and taken for granted reality *in actu* it is threatened by the marginal situations of human experience that cannot be bracketed in everyday activity. There is always the haunting presence of metamorphoses, those actually remembered, and those only sensed as threatening possibilities. There are also more directly threatening competing definitions of reality that may be encountered socially. (1966:167)

The experience of terminal illness threatens and undermines the most fundamental element of the taken-for-granted: the ongoing trajectory of the subject. Berger and his colleagues emphasise the importance of the 'significant other' in the maintenance of the taken-for-granted, and in chapter 3 I have discussed the ways in which this involves the reciprocal validation of the social world in, and through, language. In the care of the patient, and in his transition to a terminal trajectory, nurses are involved in a decisive process of secondary socialisation in which, 'the individual is also made capable of adjusting to changing and new contexts in his biography', (Berger and Kellner, 1976:29). The significant feature of this *adjustment* is the collision between two sets of definitions: one pertaining to the patient beyond the hospital, with a past and a future; and the other mobilised by those actors who structure her experience of illness. In this collision, to put it simply, the patient is outnumbered. The taken-for-granted nature of her ongoing social world is undermined by the uncertainty that characterises the period in which diagnosis and prognosis are worked out, and in the act or *rite* of disclosure it evaporates in the face of compelling news from those who *know*. The authoritative evocation of her terminal condition by medical staff; its mediation and explication by nurses; the shift to new and secluded spaces and to new objectives in conversation, combine with the patient's experience of the altered and changing state of her body to constitute this new trajectory in a concrete form.

For the nurse, this work has the effect of integrating the patient into the new career set out for her, and of giving it an order. It establishes a routine that

relates to an 'ideal-type' trajectory in which the notional patient, after a period of uncertainty, is carried through a series of encounters that lead him to recognise the inevitability of death, accepting this inevitable outcome, and thus rendering himself unproblematic. The nurse's intrusion into the sphere of the subject not only opens up the possibility of revealing its intimate character, but also offers the potential to define the reality which the patient experiences. This can only be accomplished through conversation.

The plausibility and stability of the world, as socially defined, is dependent on the strength and continuity of significant relationships in which conversation about this world can continually be carried on. Or, to put it a little differently: the reality of the world is sustained through conversation with significant others. This reality includes not only the imagery through which fellow men are viewed, but also the way in which one views oneself. The reality bestowing force of social relationships depends on the degree of their nearness, that is the degree to which social relationships occur in face to face situations and to which they are credited with primary significance by the individual. (Berger and Kellner, 1976:30)

Clearly, nurses are not the only, or necessarily the most, significant 'other' whom the patient encounters. But through establishing 'good' personal relationships with the patient, and by 'talking and listening' with her about the meaning and implications of her disorder, they render her new reality plausible and stable, and in doing so act to *sustain* this reality. It becomes real and unavoidable in their explanation of the meaning of what medical staff have said, it is elaborated in the nurse's search for psychosocial needs and fears, and is sustained through inviting the patient to speak.

### **9.5. Subjectification and integration**

In exploring the emphasis on talk in nurses' descriptions of their working relationships with terminally ill patients, I have drawn on two major bodies of social theory. First, an actor-oriented and micro-sociological perspective, grounded in the work of Alfred Schutz and Peter L. Berger: this focuses on the intersubjective constitution of the patient's trajectory through conversational practices. And second, a macro-perspective derived from the work of Michel Foucault and the 'new' medical sociology. Foucault's work offers an incisive account of the ways in which discursive practice opens up, and systematically

informs, a set of prioritised objects to be inspected through the revelation of the self. While these alternative perspectives treat the question of the subject in different ways, they have the common effect of highlighting the ways in which nursing work with terminal patients revolves around their *integration* into particular trajectories. Clearly, the practices by which the patient comes to be 'known' and individualised incorporate the notion that particular modes of practice have moral benefits. But this is only insofar as they can be negotiated through the range of factors that collectively and individually inhibit their deployment. Beyond this, while the moral and clinical benefits of 'good' interpersonal relationships between nurses and patients may not be in doubt, I would also want to suggest that this form of labour has other impacts on the nurse.

The first of these is the moral strain that it places on her (or him). The patient who resists attempts to be known and conceals his inner fears;<sup>2</sup> or who denies his prognosis or withdraws in the face of its implications; and the patient who does not legitimate the nurse's role as the bearer of *more* than the material practices of the care of the body, all have the effect of undermining the nurse's definition of her labour. Second, and perhaps more important, these *types* of patient remain outside of the ideal-type trajectory in which the patient arrives at the moment of death having resolved not only her public relationships, but also her inner fears and anxieties, peacefully and without struggle. If the job of the nurse is to make unproblematic dying possible, this can only be accomplished if the patient admits her to this process. The intimate connection here, between 'work' and 'relationships' means that this is marked not only by the material practices that are annexed to different stages in the progress of the organic disorder, but also by the engineering of encounters in which discursive practices can be mobilised. In a moral milieu in which, as one respondent tellingly put it, nurses 'have to be seen to be *doing* something' these discursive practices are – to some extent, at least – obligatory.

Work that is directed at integrating the patient into a particular trajectory has the effect, as Dingwall *et al* (1988) have observed, of making the patient more malleable. Here, 'good' relationships provide the site of work to influence

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<sup>2</sup>As Bloor and McIntosh (1990) have argued, concealment is the effective mode of resistance in the face of surveillance.

behaviour. This is important, in that every patient has the potential to disrupt the moral order of the ward through non-compliance and non-legitimation, although as I noted in chapter 8 in some cases this is viewed as 'natural' or 'understandable'. However, this disciplinary focus is not the sole effect of work which penetrates and surveys the subject. The argument that I wish to advance here is that while the modification of publicly exhibited behaviour is important, we should also see this work as being directed at the modification of the way in which the patient interprets her own experience. By this I mean that to be fully integrated into a particular trajectory any actor must freely admit to it. Coercion – to the public performance of particular behaviours – has the effect of further problematising that trajectory for all associated with it. The voluntary recognition of a trajectory and the acceptance of its outcome eliminates the moral strain that its problematic status imposes on the nurse. The speech acts and conversational practices which follow evince the effectiveness of this 'value added' labour, by offering proof of the patient's integration.

#### **9.6. The institutionalisation of personal relationships?**

Throughout this thesis I have argued that the relationship between nurse and patient is constituted through nursing *work*. In stressing the primacy of nursing work as the basic feature of the nurse-patient relationship, I have emphasised that this extends beyond material practices directed at the body, and is also configured through attempts to survey, penetrate and interpret the subject. I have also argued that this work cannot be reduced to either the function of individual nurses' preferences, preoccupations and values; or to the activation of technical skills peculiar to the knowledge base of nursing. Instead, it must be seen as a social accomplishment in which specific aggregations of practice are embedded, and which is organised through ideas which designate the appropriate sites for these practices.

This study was never intended to examine in any formal way the relationship between theory and practice in nursing. However, one effect of engaging with the broadly Foucauldian impetus of the 'new' medical sociology has been to draw into the foreground the extent to which the subject is increasingly the privileged focus of attention in medical settings. Arney and Bergen's (1984) polemic on the subjectification of patients, and Armstrong's (1983a) essay on the ways in which educational literature in nursing has come to reveal the

ways in which nurses are required to address the subject, affirm the emergence of a superstructure of ideas about idiosyncratic *persons* in medical discourse, as I have noted in chapter 2. I was at first reluctant to engage with the Foucauldian literature, and I remain uncertain about the degree to which this emergent rhetoric or vocabulary of individualisation has resulted in concrete change in the practice of medical professionals. However, I was compelled to do so because of the ways in which respondents' descriptions of their practice reveal the powerful influence that this individualising vocabulary has had on respondents' descriptions of their practice.

The first point that I wish to make here is one of comparison. A number of studies undertaken in the 1970s, and reviewed in chapter 2 point the way to this, (Clarke, 1978; Knight and Field, 1981; Melia, 1981). In these studies the disparity between nurses' aspirations for 'good' and 'meaningful' relationships with patients, and those that they were able to achieve in practice, are explained by nurses in predominantly *structural* terms. The nurse-patient relationship was impeded by the organisational context in which they were conducted, by the effects of the sexual and technical division of labour in health care; by the organisation, definition and management of nursing work; and by the power of doctors to restrict the open provision of medical knowledge to patients by nurses. Nurses' accounts in these studies emphasise the structural constraints on their autonomy and discretion which inhibit the forms which their encounters with patients take. Underpinning these accounts was the politicisation of nurse-patient relationships in terms of nursing resources. The thrust of these studies was to suggest that if nurses could be given more autonomy to define their work and more discretion in its organisation, then better relationships with patients would be the result.

These structural constraints remain in place. If anything, the environment in which nurses work is *more* hostile to the delivery of personal care to patients because of the crisis over resources which has characterised the hospital service in Britain throughout the 1980s. However, although structural inhibitions continue to form the baseline of nurses' descriptions of the problematic status of their relationships with patients, *superimposed* upon them is a new set of inhibiting factors. These take the form of judgements about the private qualities of patients. In this study respondents emphasised this: patients themselves are now given as the primary inhibitors of good interpersonal relations through which nursing care may be delivered.



The concessions made to individualised patient care through the adoption of new patterns of work organisation and the philosophies which underpin them, have added a new tier to nurses' work, and I have characterised this as *value added labour*. The recognition of psychosocial problems experienced by hospital patients in general, and the insistence of Elizabeth Kubler-Ross (1970) that the terminally patient should be encouraged to *express* their subjective reactions to the particular experience of dying, demanded that professionals took on the work of resolving this. Nurses were ideally placed to do this. It could be added to their existing work at very little cost; it raised the intellectual level of nursing work by redefining routine tasks as opportunities for therapeutic encounters; and it met nurses' own demands for more holistic and open encounters with the patients in their care. Nurses could *add* to the maintenance and observation of the body work which sustained subjects. But drawing the subject into the sphere of nurses' work has had the unintended consequence of exposing the problematic form that their relationships with patients take. The revelation of the self takes place on contested terrain: and the extent to which patients are able to exercise the power to comply with and legitimate particular qualities and modes of nursing work, and to *resist* these if they choose, is made apparent.

This raises the question of what it is realistic to expect nurses to achieve, given the limits of their resources. The philosophy of individualisation through which the apprehension of subjects is to be performed focuses on the moral qualities of participants. The nurse and patient are rendered problematic as subjects, over and above the environment in which they encounter each other. This focus on the private character of participants momentarily de-politicises the structural constraints placed on nurses, by instantiating questions about the nurse's personal competence and private feelings between the problematic encounter and the political economy of the delivery of nursing care. However, the view that I would take regarding this differs somewhat from that articulated by Dingwall and his colleagues (1988), who argue that the individualisation of patient care has the effect of confusing nurses' personal objectives with those of the institutions in which they are located. In chapter 8 I have suggested that this need not be the case, although I would certainly concede that in some



instances it is.<sup>3</sup> The organisational culture of nursing has *always* relied on the confusion of nurses' personal commitments with the formal objectives of the institutions in which they are located. In fact, I would argue that an ideology of vocational service (Williams, 1974) exerted a more powerful influence in this direction than that exerted by a professionalising ideology in combination with individualising patterns of work organisation. While the former legitimated the routinisation of nursing work and the subordination of nurses in the technical division of labour in health care by a direct appeal to 'selflessness' and 'caring'; the latter amplifies inequalities and inadequacies of service by appealing for more autonomy and a raised intellectual quality of work. The second point that I would wish to make regarding this is that while organisational cultures of nursing have always relied on drawing these personal commitments into their orbit, nurses have also found ways of working this out in their practice.

Routinised, task allocated nursing work relied on the nurse being given a sense of personal value through an ideology of selfless devotion to duty. The physical care and hygiene of the body was of paramount importance. To ensure this, nurse-patient relationships were specified in terms of formality and ceremony. But this formality, and the structural rigidities of life on the ward could be subverted by nurses acting *informally*. Here, personal encounters with patients had a moral value in humanising patient care, and in relieving the routinisation of nursing work. However, the care of *subjects* relies on notions of informal and plastic therapeutic relationships that, paradoxically, have the effect of *routinising* personal encounters. As I have suggested in chapter 2, the nurse-patient relationship has come to be constituted as a diagnostic 'moment' in which patients' psychosocial problems are to be identified and resolved. The redefinition of personal relationships as therapeutic settings demands that the nurse maintains a sense of herself as a worker even in moments of intimate familiarity, so that the search for specified problems of the subject can be accomplished efficiently.

Having reached this point, I would not want to argue that the enterprise of individualising patient care – especially in the case of the terminally ill – is wholly misconceived. If it has the effect of routinising human encounters and

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<sup>3</sup>As I have noted elsewhere. (May, 1991.)

in practice renders the personal impersonal then it clearly has the precisely the opposite effect to that which may be intended by the nurse, or desired by the patient. What I would argue is that the consequence of adding this new tier of labour to the existing field of nursing work is inevitably going to lead to some frustration. This frustration is apparent throughout the interview data which I have presented in this study, in terms of the structural conditions in which nurses encounter patients. As one respondent emphatically pointed out, this, (in combination with the extent to which patients may reject the nurse's attempt to come to know them as a subject), may engender a reluctance on the part of the nurse to attempt to apprehend the psychosocial, and on the part of the patient a reluctance to speak. The formulation of therapeutic relationships demands flexibility in a way that the administration of bodies does not: nurses are under moral pressure to enter into therapeutic relationships with patients in highly problematic circumstances in the care of the terminally ill, and while respondents endorsed the individualisation of patient care in the descriptions of their practice presented in this thesis, it is also apparent that they have difficulty finding accommodation for this in the organisation of nursing work.

## I. HANDOUT FOR POTENTIAL RESPONDENTS

### INFORMATION FOR PARTICIPANTS IN THE STUDY

#### What the study is about

My work is concerned with the ways in which nurses are able to support dying patients in hospital, and with the personal stresses and tensions – as well as successes – that they encounter when they do this. The study is not intended to be an evaluation of nursing practice and involves no observation of nurses and patients on the ward. Instead, it is aimed at obtaining the benefits of nurses' experience through detailed interviews – to obtain a picture of the practical realities of this difficult area.

#### How the study will be carried out

I am interviewing 30 staff nurses at the [hospital], all of whom have more than two years post-registration experience. Your participation would involve being interviewed and this session will last between 45 minutes and two hours. The interview is a very informal discussion of your experience of working with dying patients, rather than a strict question and answer session.

If you agree, I will tape record the interview. It is important that what you say is recorded accurately and faithfully, and taping the session is the best way of doing this. Please be assured that the interview is strictly confidential between you and I: **no information whatsoever will be given in the final report, or any published work arising from it, that can be attributed to any individual.** Only I will have access to the tapes.

#### Who is organising the study and what it will be used for

The study has two main objectives. First, it is intended to produce a detailed account of the practical difficulties that nurses experience in dealing with dying patients. Second, it is intended to use this to contribute to nurse training.

The research is supervised by Dr Kath Melia (Department of Nursing Studies) and Dr Stewart Asquith (Department of Social Policy and Social Work) at the University of Edinburgh. It is funded by the Economic and Social Research Council.

Any questions ?

I do hope that having read this you will agree to contribute to the study through being interviewed. I have enclosed a brief form - please fill this in and return it as soon as you can in the stamped and addressed envelope also provided. You may have questions about the study and I will be happy to discuss these either at the interview, or before, please don't hesitate to phone me on 667 1011 ext 6826.

I look forward to meeting you.

Carl May

## CONFIDENTIAL

1. Name \_\_\_\_\_
2. Ward \_\_\_\_\_ Extension No \_\_\_\_\_
3. Are there any periods (ie. holidays) between 5 May and 30 August when you will not be available for interview?

\_\_\_\_\_

I wish / do not wish to take part in the study.  
(Please delete as appropriate).

Signed \_\_\_\_\_

Thank you for your help. Please return this in the pre-paid envelope provided for your use.

Carl May  
Department of Social Policy and Social Work  
University of Edinburgh  
23 Buccleuch Place  
Edinburgh  
EH8 9LN

Tel 667 1011 ext 6826

## II. INITIAL INTERVIEW SCHEDULE

**Note.** As I point out in chapter 4, this interview schedule was intended only as a guide or aid to conversation. It was never delivered verbatim, nor were questions necessarily asked in the order that they are given here.

1. How long have you been on the ward ?
2. Have you worked anywhere else since you qualified ?
3. What sort of ward are you working on now ?
4. How many beds are there ?
5. How many staff ? [How many of these are qualified ?]
6. Is it a good ward to work on ?
7. Why is that ?
8. Have you done any specialist training - the Oncology Course, for example ?
9. How did you come to be on this ward ?
10. If you had to pick out the major strength of the ward you're on now, what would it be ?
11. And what would you say that the major problem is on the ward ?
12. Is it a happy ward to work on ? Would you say that people get on well with each other there ?
13. What about with patients - do you feel that you have the chance to get to know them reasonably well ?
14. One of the complaints that student nurses sometimes make is that they don't really know enough about the patients that they are nursing - and that this sometimes causes them problems if the patient asks them questions about their condition. I just wonder if the same is sometimes true for staff nurses too - would you say that you and your colleagues really have enough information about patients on the ward ?
15. Do you think that you need to know more about patients ? [If so, what ?]
16. Do you think that the nursing process has made a difference in this respect, I know that one of the things it



was intended to do was to improve the quality of information available to the nurse -- has it done that in your experience ?

17. On the ward where you're working at the moment, how would you normally find out if the patient has a very poor prognosis and is expected to die ?
18. I know that sometimes there can be problems with this - one nurse told me that she sometimes has to work things out for herself - by looking to see what's going on with them patient ?
19. Is there a general policy on your ward about what a patient is told if their illness is terminal ? [I know that in some hospitals there is a definite policy of not telling the patient]
20. Sometimes things are a bit uncertain aren't they ? I wonder how you deal with a patient who is beginning to be suspicious about the outcome of their illness ?
21. I expect you get some awkward questions at times like these ? How do you deal with them ?
22. How are patients normally made aware that their illness is terminal ? [if they are not - how do nurses explain their deterioration to them] ?
23. People react in very different ways to this sort of news, however it is given, don't they ? What sort of patient is easiest for you to deal with in these circumstances ?
24. And what sort of patient is most difficult ?
25. I think that people sometimes forget that nurses have many demands on their time, and that it's sometimes very difficult for them to spend time sitting talking to patients - but at times like these are you [is someone] able to spend time with them - while they are becoming aware of the implications of their illness ?
26. What difference do you think that you can make on a personal level to the way that a patient copes with this sort of situation - can you tell me about a patient where you have been able to do this ?
27. One or two of the nurses that I have spoken too have told me that this time - when the patient is becoming aware of what their illness actually means - is the most difficult and stressful for them as nurses. Do you think that this is true for you ? How do you cope ?
28. Do you think that as a group of nurses working together on the ward, you and your colleagues are able to find ways to cope together and support each other when things are getting difficult with a patient like this ?

29. What about those patients who might not get told about their prognosis - I know that there are sometimes good reasons for this - what sort of problems does this present you with ?
30. Once the patient knows that their illness is terminal, and that they aren't going to recover, what is the biggest problem that you feel you face with them then ?
31. Are there ways in which you are able to deal with that ?
32. How do they work out in practice ?
33. I wonder, do you ever feel that there is a distinction between what you are doing to the patient as a nurse, and how you would like to be with them as a person ? [A couple of nurses that I have spoken to have told me that there is a real difference to them between the way in which they spend a lot of time dealing with the symptoms of an illness - and the way in which they would like to respond to the patient as a person. How do you feel about that ?]
34. Conventionally, these things tend to be spoken about in terms of how much time nurses are able to spend talking to patients - but it's possible to talk to patients without saying too much isn't it - I'm interested in this because one nurse has told me that she spends quite a lot of time talking to patients, cheering them up and so on, but always about things that meant that she didn't have to get too involved with them, because she was afraid that when they died she would be hurt - and that this would happen over and over again. Do you ever feel that way ?
35. As you know, I'm not a nurse, but I imagine that it must be very difficult to keep yourself from becoming emotionally exhausted. How do you manage ?
36. Are there ways in which you can organise your work to prevent problems like the one we've just been talking about from getting started ?
37. Most of the nurses that I have spoken to have told me that they feel that to nurse a patient 'properly' they feel that they ought to get involved with patients. But how involved do you think that you can realistically expect to get ?
38. I'm interested in this because one nurse was telling me that she felt that there was a conflict between what she felt was expected of her - that on one hand she should be 'professional' and 'stay detached' - while on the other hand she felt that she was expected to get intimately involved with people who she hardly knew. She felt that she could manage this if they were going to go home and get better - but that it was very difficult with people she knew were going to die. How do you feel about this ? [Is it very difficult sometimes ?]

39. We have concentrated very much on you as an individual: do you think that people sometimes forget that nursing is something that you do as a team ?
40. It's important that you're all working together and, that you're getting support from your colleagues isn't it?
41. What happens when nurses on the ward disagree about how to handle a patient ? How does it get sorted out ?
42. What about student nurses: they learn pretty much as they go, don't they, but I expect you sometimes get asked for advice about how to deal with difficult situations when a patient is dying. What sort of things are they worried about do you think ?
43. I think that in the handout I sent you, I told you that this study has an educational objective didn't I. If you had to hammer home one lesson to students coming on to the ward about how to cope with dying patients - what would it be ?
44. The general impression that I get is that nurses are much better at 'letting dying patients go' than doctors. Do you agree ?

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